Long Term Care Review

Future Scenarios: Continuing Care Service Needs in Alberta

November 1999

This project report was prepared for and submitted to the Policy Advisory Committee of the Long Term Care Review by KPMG.

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ISBN 0-7785-0219-8

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Executive Summary

In November 1998, the Policy Advisory Committee on Long Term Care, a committee appointed by the Minister of Health, contracted KPMG to conduct a special study to develop future scenarios to address and forecast the continuing care service needs in Alberta to the year 2016. Over a period of seven months, we worked closely with the Committee, including a smaller working group of the Committee.

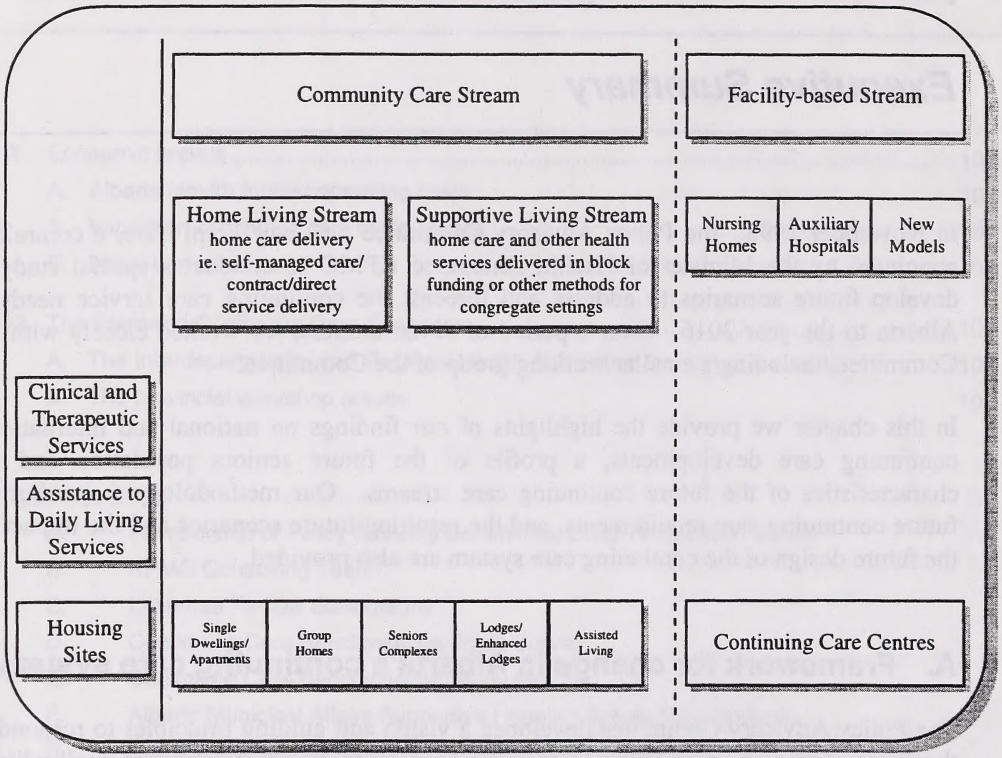
In this chapter we provide the highlights of our findings on national and international continuing care developments, a profile of the future seniors population and the characteristics of the future continuing care streams. Our methodology to predict the future continuing care requirements, and the resulting future scenarios and the impact on the future design of the continuing care system are also provided.

A. Framework for change in Alberta's continuing care system

The Policy Advisory Committee developed a vision and guiding principles to respond to the needs of an aging population. The vision focuses on the achievement of quality living for older persons by treating them with respect and dignity, enabling them to make responsible choices and supporting them in their living situation through personal and community networks and a responsive service system. The guiding principles assert the values to achieve the vision and address wellness and prevention, a client-centred approach, accessible information, individual and shared responsibilities, system effectiveness and efficiency and the importance of an intersectoral approach.

Using the vision and guiding principles the Committee developed a framework for change that views the provision of services in the future continuing care system in three streams: facility-based care, supportive living and home living. The latter two streams focus on the provision of care in the community environment while offering clients a range of service and housing options to meet their needs. This framework is important as it provides the foundation for the development of the future scenarios. Exhibit I-1 presents the framework.

Exhibit I-1
Continuing care framework for change



B. National and international continuing care developments

We conducted a literature review to determine the current developments in continuing care across Canada and other selected countries, targeting those with significant aging populations and experience in responding to growing demands and needs in an environment of public fiscal constraint. Our review focused on developments the Netherlands, Denmark, Sweden, Australia and Ontario.

Our major findings were:

- An increasing focus on home living options—24 hour service provision, home adaptations to support resident needs and their subsequent care requirements. For example, The Netherlands supports "grow-along houses".

- A declining focus on building institutions. Clients are only admitted to facilities when their care costs in a home living environment become prohibitive. In Denmark, a moratorium on facility construction was declared and accompanied by major incentives to encourage alternative living arrangements in the community.

- A de-linking or unbundling of health, social services and housing. Service options, subject to client choice, are available independent of the housing arrangement. In the past the housing arrangement also dictated the nature of available services as they went hand in hand. This is most prevalent in The Netherlands, Denmark and Australia.

- More funding flowing to individuals and moving with individuals giving them the choice in their service selection. In the past, funding was associated with the asset rather than the individual. This strategy facilitates the unbundling of the service and housing components. For example, in the Netherlands, personalized care budgets are provided.

- An increasing array of community service providers either through public or private home care organizations, introducing an element of competition and increasing focus on quality of services. Clients have more options from which to choose, requiring informed decision making.

- An increasing reliance on the private sector for the housing component. The private sector is also expanding into the provision of health and social services. This is particularly noted in Sweden.

We also conducted a benchmarking study to identify bed planning and service planning guidelines and approaches and current utilization patterns in other provinces and selected countries. We also obtained descriptive information on the continuing care programs and services offered. Our benchmarking survey resulted in information from all Canadian provinces and the territories (except Quebec who had not responded at the time of writing this report), The Netherlands and Denmark.

Our major observations from the benchmarking survey were:

- All provinces offer continuing care services in the three streams (facility-based, supportive living and home living) although the terminology used from one province to another varies widely, particularly in the institutional sector, reinforcing the importance of definition clarity when drawing comparisons. Of the three streams, increasing attention is being focused on the home living stream and the supportive living stream. However, the supportive living stream is the least developed and an area of growing demand.

- Eligibility criteria and service guidelines for the home living stream are fairly similar across Canada. All have age and residency requirements. Most have maximum service limits in the home living environment that when exceeded, require a reassessment for referral to a continuing care centre.

- All provide a range but standard package of professional and support services using a variety of service providers.

- Most provinces have delegated service delivery to regional health bodies. Service delivery approaches vary across the country with a higher and growing involvement of the private sector (contracted through the public sector) in the provision of support services, institutional care and other housing arrangements. In some provinces, the private/voluntary sector is involved in the delivery of professional health services such as the VON. Housing alternatives and related services are provided through a variety of government departments, often separate from the health department and delivered through municipal government or other housing authorities.

  Internationally, municipal governments may play a role in the delivery of all health and social support services, including housing.

- All provinces have developed streamlined assessment procedures and some form of classification system, although the assessment processes and classification systems vary across the country. As well, several provinces are in the process of upgrading their assessment and classification systems. Case/care management services are also provided in all provinces.

- Professional services are provided without any cost to the client. Support and housing services most often require client fees that are income and, in some cases, asset tested. The amount of fees to be paid by the client are capped.

  Internationally, clients are given the option to purchase additional services should they desire them beyond the need assessed through the public system.

- Caregiver respite is available in most provinces and includes day and night programs options, either in a community living or institutional setting. However, most provinces do not have any provisions to reimburse family members who may have extensive involvement in the care of their family members.

- Planning approaches, information systems and databases are in different stages of development across Canada so bed and service planning guidelines and specific utilization rates were largely unavailable. A specific and separate research effort to obtain utilization rates is required.

C. Profiles of the future senior and the continuing care streams

We conducted research to examine the trends characterizing the senior population and the impact these trends may have on the nature of the senior citizen in the year 2016. Our major conclusions are that Alberta's senior population is expected to be characterized by:

- **More education** resulting in more informed consumers with increased demands for service options and choice, as well as having the capability to manage their own care.

- **More income** resulting in an increased willingness to pay for desired care and living options. The portion of low income seniors will be less but will, nonetheless, require subsidy programs to meet their needs.

- **Improved health** resulting in fewer dependencies reinforcing the demands and desires for a range of care and living options.

- **Accommodation apart from the extended family** resulting in increased demands for housing alternatives and workplace attention to elder care benefits for working family members.

- **Accommodation at home** resulting in increasing demand for choice, service options and service flexibility, as well as home adaptations to accommodate aging in place.

- **More active lifestyles** influencing the types of recreational and social programs that will be desired, including the ways and means to readily access them.

- **More technological capabilities** strengthening the use of technological aids in the home and enhancing the capability for self-managed care.

The future scenarios for the three continuing care streams were also described. A summary of their key characteristics follow.

- **Home living stream**. The home living stream involves private residential settings and focuses on seniors with fewer functional dependencies and care needs. Case/care management is provided to coordinate an array of professional and support services. The informal support system offered through families and friends will continue to be a critical factor in supporting home living. Home living is expected to experience increased demand as the population ages. The majority of older Albertans currently live in their own homes and have indicated their desire to continue to do so for as long as possible. The length of time that seniors are able to stay in their homes will

depend on a number of factors, including their functional capacities and the available support systems and services.

- **Supportive living stream.** The supportive living stream involves congregate or group living arrangements in a variety of housing alternatives. Services may vary by the type of housing arrangement and may be unbundled from the housing component. The supportive living stream is characterized by the range of needs that can be accommodated (medium care needs and dependencies) and the subsequent service arrangements that can be provided. The "high end" of supportive living is typically viewed as assisted living while the "low end" is viewed as supportive housing.

  Assisted living is a reconceptualization of long term care services for special needs populations. This reconceptualization underlies a redefinition of the role of the environment, the enhancement of care service capacity and a shift in values about how care is provided. In short, individuals receive individualized personal and/or health services in "homelike" accommodation that promotes privacy, space and dignity. Supportive housing is more likely confined to specific tasks related to the management of the housing property and the availability of specific housekeeping services. Supportive housing is likely to include services related to personal care management or health monitoring. This type of housing and service arrangement is expected to increase.

  The supportive living stream is experiencing increasing demand. More older adults are opting for supportive housing arrangements that may also provide options for additional health and support services that may be required as individuals age. The demand for the flexibility offered by this stream is expected to grow and, may over time, have more appeal for the emerging generation of older persons.

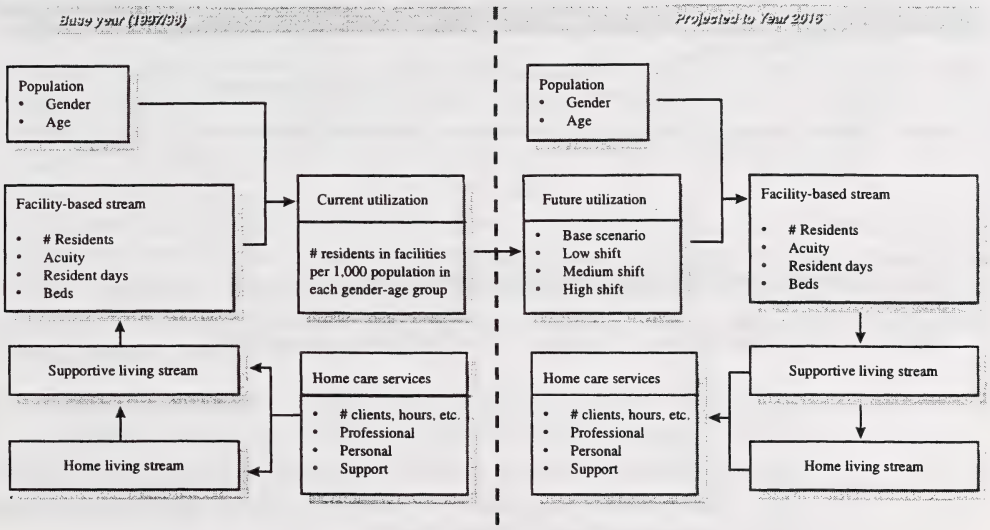
- **Facility-based stream.** The facility-based stream will continue as a system of continuing care centres available throughout the province. Continuing care centres will provide 24 hour professional and personal support services to individuals with high physical and cognitive needs and dependencies. Ownership of these centres will continue to vary from those publicly owned and operated by the Regional Health Authorities to those that are owned and operated by the private and voluntary sectors. Over time the private and voluntary sectors are expected to play a greater role in the ownership and operation of continuing care centres.

As other living alternatives become available, it is expected that the demand for facility-based care will stabilize over time. While a portion of the population will experience major physical and cognitive disabilities, this portion will likely enter continuing care centres at an older age and experience shorter lengths of stay, thus, increasing the overall through-put in a facility.

D. Study focus

Our forecasting model incorporated three key elements—population, service volumes and utilization rate. The model, shown in Exhibit I-2, includes a base year that establishes the current utilization rate of facility-based, supportive living and home care services. The future forecasting component projects the service volumes in the various streams based on a number of utilization scenarios and population projected.

Exhibit I-2
Forecasting model



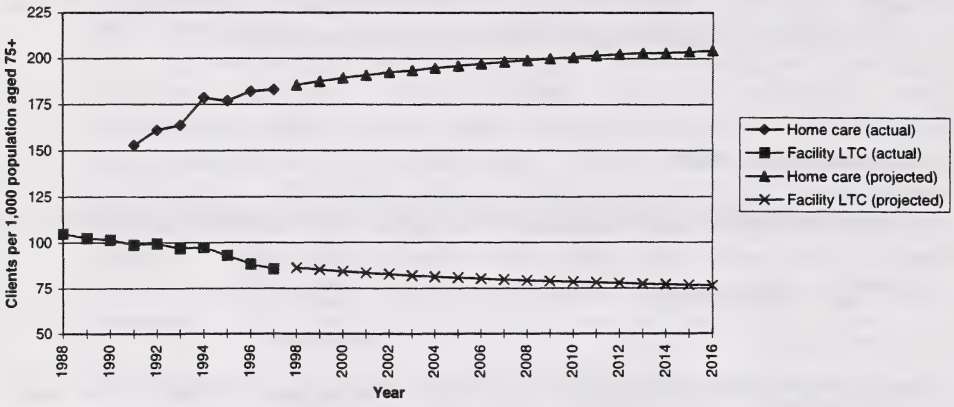
According to the population model developed by Health Surveillance within Alberta Health, the population is projected to increase from 2.8 M in 19997 to 3.8 M in 2016. This represents a 35% growth in total population over a 19 year period.

The highest annual growth rates will be seen in the older age categories. The number of individuals aged 85+ will grow at an annual rate of 4.1%. Overall, the population aged 75+, the main users of continuing care services, will grow by 65%.

E. Utilization trends

Utilization rate for facility-based services in Alberta has declined from about 105 residents per 1,000 population aged 75+ in 1988 to 86 in 1997—a decrease of 18% over a nine year period. At the same time, the utilization of long term home care services has increased from 153 clients per 1,000 population aged 75+ in 1991 to 183 in 1997—an increase of 19.6% over this period of time. As shown in Exhibit I-3, we continued this trend into the future for the purposes of developing the Base scenarios for these services.

Exhibit I-3
Base scenario assumptions



F. Future facility utilization scenarios

We developed four utilization scenarios for facility-based services:

- **Base scenario** that features a slight decline in facility-based utilization rate related to improved health, higher income and demand for alternatives. The utilization rate would decline about 11% over the 19 year period from 1997 to 2016. This scenario can likely be achieved with no significant changes in policies or direction from Alberta Health.

- **Scenario 1** or "low shift" scenario incorporates a further decline in the facility-based utilization rate for those individuals with light to moderate care needs (classification A to E). Scenario 1 assumes a 50% reduction in utilization rate for A's to a 30% reduction in utilization rate for E's.

- **Scenario 2** or "medium shift" scenario features a moderate decline in facility-based utilization rate for those with light to moderate care needs. This scenario assumes a 100% reduction in A's to a 60% reduction in E's.

- **Scenario 3** or "high shift" scenario features a major decline in facility-based utilization rate for those with light to moderate needs. This scenario assumes a 100% reduction in A's to an 80% reduction in E's. The major focus will be on F's and G's.

The approach taken to modeling the future care scenarios started with the facility-based services and then calculated the impact on supportive housing services and the provision of home care services based for residents that were "shifted" from continuing care facilities. In reality, adequate supportive living and home care services will need to be in place in order to achieve the facility-based utilization scenarios by preventing and/or delaying admission to continuing care centres.

G. Projected service volumes

Projected services volumes under each of the scenarios are summarized in Exhibit I-4.

Our projections show that a total of 21,746 beds would be required in continuing care centres in 2016 under the Base scenario. In Scenario 1, 2,881 individuals would be "shifted" to alternative living arrangements. In the Base scenario, these individuals would continue to reside in continuing care facilities. An increasing trend to shift residents to alternative living arrangements is seen in Scenarios 2 and 3. A total of 7,335 and 9,061 individuals would be shifted to alternative living arrangements under Scenarios 2 and 3 respectively.

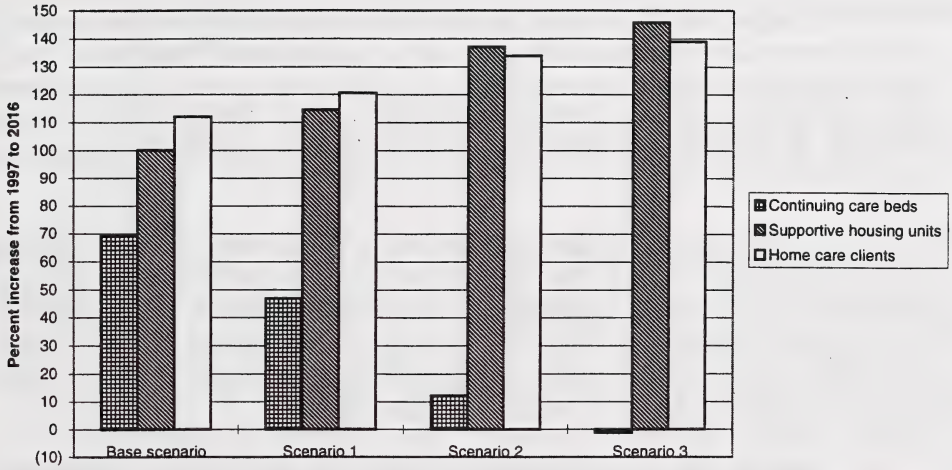
We assume that 80% of the shifted residents in Scenarios 1 through 3 would live in a supportive housing situation with the remainder living in a private dwelling. Individuals in both supportive housing and private dwelling situations would require home care services. Base scenarios of occupied supportive housing units and home care clients have been increased accordingly.

Exhibit I-4
Summary of forecast service volumes to 2016

Service units	1997	2016	Increase (decrease) Volume	%	Per year
Base scenario					
Facility-based beds	12,844	21,746	8,902	69	469
Occupied supportive housing units	15,859	31,731	15,872	100	835
Long term home care clients	33,590	71,211	37,621	112	1,980
Scenario 1 - low shift					
Facility-based beds	12,844	18,865	6,021	47	317
Occupied supportive housing units	15,859	34,036	18,177	115	957
Long term home care clients	33,590	74,092	40,502	121	2,132
Scenario 2 - medium shift					
Facility-based beds	12,844	14,411	1,567	12	82
Occupied supportive housing units	15,859	37,599	21,740	137	1,144
Long term home care clients	33,590	78,546	44,956	134	2,366
Scenario 3 - high shift					
Facility-based beds	12,844	12,685	(159)	(1)	(8)
Occupied supportive housing units	15,859	38,980	23,121	146	1,217
Long term home care clients	33,590	80,272	46,682	139	2,457

Exhibit I-5 provides a graphic summary of the impact of the three scenarios on the three streams.

Exhibit I-5
Summary impact of continuing care scenarios



H. Economic impact

Our high level analysis of the economic impact of the various continuing care scenarios is presented in Exhibit I-6.

Exhibit I-6
Average annual Alberta Health cost from 1998 to 2016 ($M)

Scenario	Operations	Capital costs	Total
Base	812.2	70.3	882.5
Scenario 1	784.9	47.5	832.4
Scenario 2	747.0	12.4	759.4
Scenario 3	732.5	(1.3)	731.2

Average annual cost (i.e., from 1998 to 2016) that is currently funded by Alberta Health will be $50.1M lower for Scenario 1, $123.1M lower for Scenario 2 and $151.4M lower for Scenario 3 when compared to the Base scenario.

Consideration should also be given to individual payments associated with resident charges in continuing care centres, rental charges in supportive housing and individual dwellings and subsidies provided by provincial and/or municipal government agencies and capital costs for additional supportive housing units.

I. Preferred future continuing care scenarios

Two focus groups (Interdepartmental and Regional Health Authorities) and a provincial workshop were held. The focus groups provided an opportunity to review the initial work done on the future scenarios and resulted in some fine-tuning. Overall, the participants in both focus groups supported a medium to high shift that would result in decreased utilization of facilities and increased utilization of the supportive and home living streams.

At the provincial workshop in June, 1999, conducted by the Policy Advisory Committee, over 140 participants representing regional health authorities, provincial government departments and provincial organizations, received information on the proposed future continuing care scenarios for Alberta. Participants then worked in small groups to discuss the preferred scenario and the resulting policy implications. The results from the eight groups regarding the preferred future scenarios were:

- **Four groups selected Scenario 3**—the "high shift" scenario that focuses on enhancing alternative living arrangements and reducing reliance on the facility-based system. This scenario was viewed as most consistent with seniors' expectations and their future preferences, as well as providing the most flexibility in the system, and at the same time assuring its affordability and sustainability.

- **Three groups selected Scenario 2**—the "medium shift" scenario that provides for more alternative living arrangements but also provides for more bed capacity in the overall system. The groups selecting this scenario felt it was more realistic with respect to the timeframe, affordability and sustainability but yet enables seniors to maintain their independence for as long as possible. This scenario was also viewed as better accommodating those with low physical and cognitive needs that may prefer assistance and socialization in a group-like living arrangement.

- **One group selected Scenario 1 initially, then moving to Scenario 2**—the "low shift" scenario that continues to have a major focus on the facility-based sector. This group identified a "pent-up" continuing care need in the existing system that requires increased bed capacity in the system, stressing that any new facilities need to be flexible in their design. "

The policy implications for each of the scenarios were also discussed. The implications were categorized in three topic areas:

- **Service provision**—questions addressed changes to eligibility criteria, type of services to be offered, and human resource requirements.

- **Funding**—questions addressed the responsibility for paying for professional services, personal care and support services, housing (capital costs, housing and operating costs) and the funding of services (cost sharing/subsidy structures).

- **Legislation and standards**—questions addressed changes needed to legislation, the need to develop standards, responsibility for monitoring the system and the potential roles for the private and voluntary sectors.

A summary of the policy implications identified by participants is contained in Appendix G. Overall, the preferred direction for addressing the future needs of an aging population will require adjustments to existing policies. Future policy provisions need to allow for flexibility in the system to accommodate a wide range of needs, preferences and funding options, including potential housing partnerships offered through the private and voluntary sectors. Existing incentives and disincentives need to be addressed to enable a fair and reasonable access to the most appropriate service and housing arrangements. Information will need to be available so individuals and their families may exercise informed choices and enjoy a high quality of living as they age—living with dignity and respect. With responsive services and supportive networks, the new vision for meeting the needs of an aging population will become a reality.

II

Introduction

A. The background

Like many provinces and nations, Alberta's population is aging. In November 1997, the Minister of Alberta Health established the Long Term Care Policy Advisory Committee to address issues related to an aging population. The specific purpose of the committee is *to provide advice and make recommendations to the Minister of Health on priority policy issues and strategies for addressing the impact of the aging population in the health system.* The priority areas include home care and facility based care, health related support programs and policies, drug provision and utilization policies and programs, and health related accommodation support programs and policies.

In November 1998, the Policy Advisory Committee contracted KPMG to conduct a special study to develop future scenarios to address and forecast the continuing care service needs in Alberta to the year 2016. Over a period of seven months, we worked closely with the Committee, including a smaller working group of the Committee. The list of the members on the Policy Advisory Committee and the Working Group is contained in Appendix A. Appendix B gives the names of the members on the KPMG consulting team.

Five objectives were articulated for the project:

- Describe bed-planning and service-planning approaches and bed and service utilization of the Canadian provinces.
- Describe bed-planning and service-planning approaches and bed and service utilization of selected countries with aging populations.
- Develop four scenarios for continuing service needs based on the survey of "best care practices".
- Suggest policies and strategies for adoption for each scenario.

- Complete a final report that includes background information, describes the study methodology and provides the findings and recommendations on the future scenarios.

The project was completed in four phases. Given the significance of the future scenarios to the planning initiatives in Alberta, additional meetings and focus group sessions were held to consult with experts and providers. Specifically, focus groups were held with departmental representatives (Health, Social Services, Municipal Affairs, Public Works, Health Surveillance), academic representatives, management and program representatives from the regional health authorities. In June 1999, a provincial workshop was held to review the future scenario framework and the proposed scenarios for Alberta to the year 2016. The workshop involved representatives of various government departments, regional health authorities, community health council representatives, and provincial organizations.

In the remainder of this document we provide key project deliverables and describe our findings for consideration by the Long Term Care Policy Advisory Committee. This report is presented in ten chapters:

Chapter I is an executive summary and presents the highlights of the project.

Chapter II gives the introduction, background and the framework for change in the continuing care system that was developed by the Policy Advisory Committee.

Chapter III contains the literature review.

Chapter IV contains a summary of the results of the benchmarking study.

Chapter V describes the framework developed for the continuing care future scenarios and includes a description of the anticipated characteristics of the senior population to the year 2016.

Chapter VI provides an overview of the methodology used to predict the continuing care requirements in Alberta, and presents the population assumptions used in the model.

Chapter VII presents the baseline information associated with facility-based services in 1997/98 and describes four future scenarios for utilization of facility-based services.

Chapter VIII presents a description of the existing inventory of supportive housing units from available databases and projects the impact of the shift of residents from continuing care centres on supportive housing.

Chapter IX provides a quantitative description of the long term home care services that were provided during 1997/98 and projects the service volumes that will be required under each future continuing care scenario.

Chapter X presents a high level analysis of the economic impact of the various continuing care scenarios.

Chapter XI presents a summary of the outcomes of the provincial workshop that was held to discuss the baseline and proposed future scenarios.

B. Vision and guiding principles for an aging population

To provide a foundation for the subsequent chapters, we describe the continuing care framework that was developed by the Long Term Care Policy Advisory Committee. This framework serves as the building block for the future scenarios that were developed.

The vision for the continuing care system in Alberta describes the future direction for those individuals who are and will be needing continuing care services. The guiding principles speak to the values to be reinforced and integrated as the system continues to develop in meeting the needs of the service recipients, the providers and governments at all levels. Adhering to the values in pursuing the vision is critical in building integrity throughout the system. Future policy directions and service approaches need to reinforce these values as the system develops and moves forward. The vision and the guiding principles for addressing an aging population follow.

Vision of Aging for Albertans in the 21st Century

Our vision for aging in the 21st century is a society where all Albertans:

- Are treated with respect and dignity.
- Have access to information which allows them to make responsible choices regarding their health and well-being.
- Can achieve quality living, supported as needed by relatives, friends and community networks, and by responsive services and settings.

Guiding Principles to Help the Health System Respond to an Aging Population

Wellness and Prevention

The system should:

- Support healthy aging for all Albertans
- Emphasize promotion of health and prevention of illness, injury and disease
- Help Albertans to cope effectively with chronic conditions and function to the best of their abilities

Client Centred

The system should:

- Endeavor to understand and meet client and family needs, work in partnership with clients and ensure client choice where possible
- Acknowledge the client's right to dignity and self-determination
- Have reasonable access to a variety of affordable services and have their needs met in a flexible, timely and responsive manner
- Respect the client's right to privacy of space and person
- Recognize and respond to the physical, psychological, spiritual and social aspects of health

Information

The system should:

- Provide clients with access to information required to make informed choices and decisions regarding care and services
- Ensure confidentiality of personal information, however, allow appropriate sharing of information to support the highest quality of services and best possible outcomes.

Individual and Shared Responsibility

The system should:

- Encourage independence by assisting Albertans to reach their greatest potential, recognizing that clients and families have the primary responsibility for their own health
- Recognize the concept of interdependence and facilitate collaboration between Albertans, community and government

Effectiveness and Efficiency

The system should:

- Make decisions based, as much as possible, on the values of the consumer, on evidence provided through research, evaluation and technology assessment and available resources

Intersectoral Approach

The system:

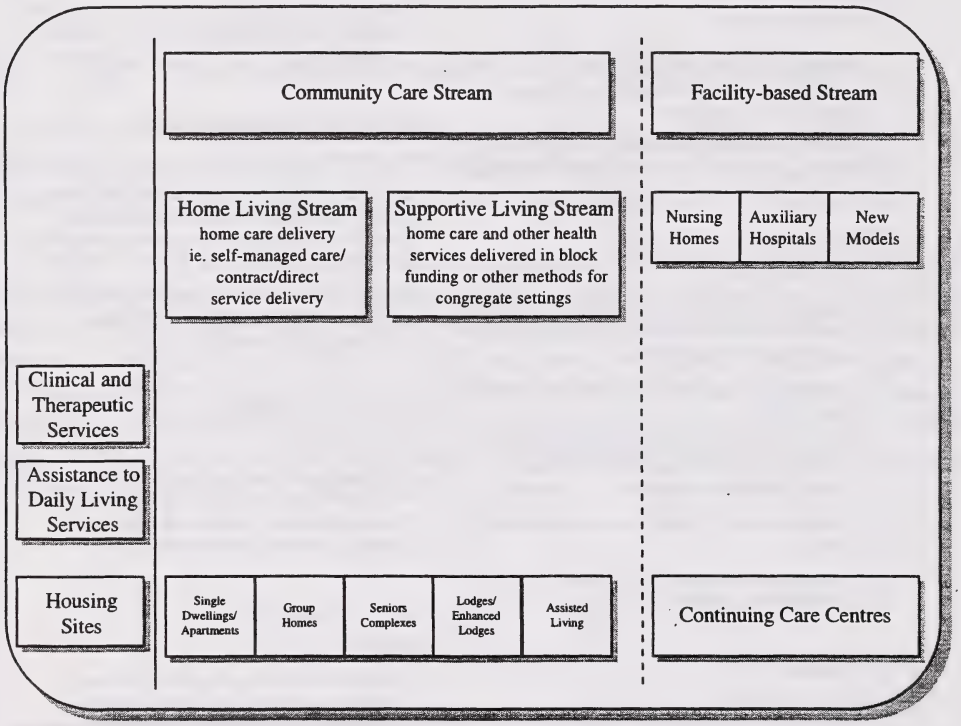
- Recognizes by working together, Albertans, government, regional and provincial health authorities, non-governmental organizations and the voluntary and private sector all have an active role in contributing to the health of Albertans.

Source: Policy Advisory Committee. Long Term Care Review. 1998.

C. Continuing care framework for change

A framework for change in the continuing care system was also developed. This framework describes three streams which portray the nature of the infrastructure required to support the vision. The following exhibit shows the continuing care framework for change.

Continuing care framework for change



At the highest level the three continuing care streams are segmented into two sectors—the community living sector and the facility-based sector. From there, a further segmentation takes place in the community living sector to differentiate the housing arrangements between people's own private home settings and those that are congregate settings—the home living stream and the supportive living stream respectively. Across all sectors, three basic service groupings are available—clinical and therapeutic services, assistance to daily living services and housing services/sites. The framework provides for a wide variety of options in the bundling and provision of these services linked to or independent of the specific housing sites. As such it provides a flexible framework for designing the future continuing system.

III

Continuing Care Literature Review

In this chapter we present the results of our literature review to identify current developments in continuing care in other Canadian provinces and selected countries. Given their high proportion of seniors, we targeted four Canadian provinces: British Columbia, Ontario, Saskatchewan and Manitoba. We also targeted five countries to explore innovative approaches and policy directions with respect to meeting the needs of an aging population: United Kingdom, Sweden, Netherlands, United States and Australia. In the sections that follow, we describe our literature search strategy, our review of the literature and a summary of the major trends. The bibliography is contained in Appendix C.

A. Continuing care literature search strategy

Our literature search focused on the MEDLINE 1995 to December 1998 database through the University of Alberta on-line system. Our search strategies involved the following combination of terms:

- Continuing care or long term care or home care or chronic care or supportive living or assisted living or nursing home or seniors lodge.

AND

- Funding model or payment model.
- Service model or delivery model or planning model.
- Staffing model or human resource management or manpower.
- Trends or utilization.

In many cases, the University of Alberta search engine translated the above search terms into MEDLINE-compatible search terms (e.g., group homes, homes for the aged, residential facilities).

The resulting articles were limited to:

- Two age categories: 65 and over (seniors) and adult 19-44 years (young disabled).
- Journal articles (as opposed to opinion articles and editorials).
- English language articles.
- The latest updates of the articles.

In addition to the above structured literature search, a further literature search was conducted through the Alberta Health Library. The specific parameters for this search were:

- Countries: Sweden, Finland, Belgium, Great Britain, Canada.
- Subjects: long term care, home care services, housing for the elderly, health services for the aged.
- Models: Economic, organizational (including personnel management), service (including delivery of health care), funding
- Journal articles: English language, those aged less 65 years, those aged 65 years and older; those aged 80 years and older.

Abstracts for the resulting articles were perused. Those determined to meet the established parameters of this literature review were obtained for review. The results of the review follow in the next section.

B. Selected continuing care provincial and international developments

In this section we describe general global aging trends, including the economic and service model trends. Specific developments in continuing care are described for the Netherlands, Australia, Sweden, Denmark and Ontario.

1. An aging population—a global trend

The increase in the number of senior citizens is a trend that all countries are experiencing, not just those in North America. While the rates vary from country to country, the projected numbers for the next 25 years show dramatic increases in the proportion of individuals who will be over the age of 65. In 1990 11.5% of

Canada's population was over the age of 65, compared to 17.8% in Sweden, 14.1% in France, and 15.4% in Germany (Brink 1998). However, by the year 2020 when Canada's baby boom generation become seniors, this figure is expected to increase to 20%, similar to that of many European nations (Brink 1998).

One of the reasons for the increase in the proportion of seniors in society is that life expectancies in almost all countries have gone up. Improvements in sanitation, health care and education have led to people living longer lives (Brink 1998). Exhibit III-1 shows life expectancies for a number of countries in 1960 compared to 1992 (Brink 1998).

Exhibit III-1
Life expectancy at birth, in selected countries, 1960 and 1992

Country or country category	1960	1992
Canada	71.0	77.2
All industrial countries	69.0	74.5
All developing countries	46.2	63.0
World	53.4	65.6

Source: UNDP, 1994.

Another trend that coincides with the aging population is the increase in urbanization. At one time the world's largest cities were in industrialized nations, but now developing countries in Asia and South America contain the majority of the world's 10 most populated cities (Brink 1998). These two trends have important implications for the care of the elderly, and three paradoxes are beginning to emerge:

- Elderly persons require the number and the range of services typically offered in larger cities, but because of fixed incomes many seniors can not afford to live in cities.

- There is a positive correlation between low income and poor health and disability, therefore the elderly who are in most need of special housing and services are the ones who can least afford it.

- Demand for elderly care is increasing while the supply of informal care is decreasing because of demographic and economic factors. (Brink 1998)

Developed nations have some common obstacles to overcome. The number of people living past the age of 80 years will sharply increase compared to previous times, which will have a significant financial effect on health care because individuals above this age require significantly greater medical and living assistance (Brink 1994). Seniors are more financially secure now than in the past, as only 9% of couples over the age of 65 were classified as poor in 1991, compared to 22% in 1980 (Brink 1994). However, they are demanding an increase in the number and the quality of services, and because they represent an ever growing increase in the electorate composition, politicians are giving this group greater attention than in the past. In addition, most countries are facing increased economic challenges. In 1992, the budget deficit as a percentage of GDP was 39.4% in Canada, 43.9% in France and 36.6% in Germany (Brink 1994). As a result, countries are looking for ways to decrease spending, and therefore are reluctant to increase funding for seniors' long-term care.

All nations, not just Canada, are being forced to address the issue of an aging population. With the increased numbers of the elderly, governments are facing increases in expenditures to care for them at a time when economic factors are shrinking budgets. Because the proportion of seniors has already dramatically increased in some countries such as Sweden, experiments are being conducted to find solutions. The following section describes the challenges and attempts to overcome them by several countries.

2. Financing models

Brink (1994) describes three common models that can be used to describe the manner in which governments distribute funding for health, social services, and housing.

- The integrated cross-sectoral financing model.
- The co-ordinated multi-sectoral model.
- The co-located sectoral model.

a) The integrated cross-sectoral financing model

The health budget dependent model

In this model, funding for housing flows from the government's health budget. The impetus for this model was an attempt to free up hospital beds that were being used for long term care. Because health budgets tend to be quite large, this model was deemed an appropriate way to avoid building more hospitals to accommodate bed needs.

There are several shortcomings to this model. Housing construction requires large capital outlays, and as the proportion of seniors increases continuing this type of funding is becoming cost prohibitive. Funding the creation of long term fixed assets restricts future flexibility for meeting needs, as buildings typically have a 40 or 50 year life. Conflicts typically arise between those in social services and those in primary health care because of competition for funding. This type of funding tends to follow the medical model providing low quality shelters with health and social services on-site, which leads to higher costs.

The housing budget dependent model

This model directs funding from housing budgets to subsidize the construction of housing and to provide social services for seniors. The private sector is typically involved in the financing and the construction of the physical facilities. Operating subsidies cover the costs of housing and services. This model has a smaller emphasis on meeting medical needs compared to the health budget model, and focuses more on the residential and service components. The United States Congregate Housing Program is an example of this model.

As with the health funded model, disadvantages are becoming evident with this type of funding. As with the previous model, flexibility is lost because large amounts of funding are used to construct long term assets. Competition for funding exists between seniors and other groups requiring special housing. Typically only the poorest of the seniors can access special housing under this funding arrangement, and, thus, inequities exist even between elderly groups. Seniors who live in these types of facilities pay rent or outright purchase the dwellings, but have little say in the services provided in them.

b) The co-ordinated multi-sectoral financing model

In this model, funding for housing come from each of the health, social services and housing budgets through joint funding or partnerships. Because funding flows into the housing component, seniors only benefit from the programs when they live in the housing facilities. Health and social services are usually provided on-site, and can be tailored to the particular type of facility so a degree of flexibility exists in their design. The main difficulty with this model is the high amount of co-ordination required to access funding from all three budgets. Applications for funds usually have to be made to each government department. The departments may have different priorities, or may be governed under different jurisdictions which complicates the process. Projects tend to be slow to gain acceptance because of the multi-levels of approval required and because of the inherit bureaucracy when dealing with

three department that have different regulations. Another difficulty is that funding flows to housing so flexibility is lost, and only a small proportion of seniors benefit from the facilities.

c) The co-located sectoral financing model

There are two key elements to this model: funding flows to individuals not assets, and funding comes from two sources, usually health and social services. There are many benefits to this model. Because funding flows to individuals, there is generally a more equitable distribution of funds compared to the other models in that all seniors are able to access funding. Seniors can receive benefits regardless of where they live. The senior also has a large degree of autonomy in selecting the types of services to be received rather than being forced to accept pre-set services in a facility. Social services and health benefits are portable so that they may be received in private or residential settings. Because seniors can choose their service providers, a degree of competition exists which assists to increase the level of quality and decrease the costs of the services. This is the type of model used in Sweden.

The main disadvantage of this model is that a well-developed social policy infrastructure must be in place. Also, a good supply of quality housing must be available to provide this type of flexibility in the system. Because the government does not produce or operate the goods and services, the private sector must be present and capable in widely geographically dispersed regions to provide these.

Conclusions

Governments are tending to shift to the co-located financing model because of the flexibility it offers compared to other models. Because funding flows to individuals and not assets, seniors can choose the services they require and the agency to provide them. Health and social services are increasingly being de-linked from housing to also increase flexibility. As the number of seniors continue to increase relative to other age groups, and as they use their political power to influence decision makers, greater options for housing, health and social services will become more prevalent.

3. Housing and service models

Solutions for housing and serving the elderly tend to be classified into three categories: independent living, semi-independent living and institutional living. While most countries use mixed strategies, the strategies tend to center primarily around one of the categories:

- Independent living—seniors continue to live in their own housing in the community and access health and social services externally as needed.

- Semi-independent living—seniors continue to live in their own housing but rely on some social services such as food and cleaning services on-site, and access health services externally as needed.

- Institutional living—health, social services and housing are merged into one entity for seniors (Brink 1994).

4. The international perspective

a) The Netherlands

Van Egdomm (1995) provides the following description of elderly care in the Netherlands.

History

After World War II, elderly people living in The Netherlands were encouraged to move to newly built homes specifically built for seniors. This trend continued throughout the fifties and sixties, and by 1985, The Netherlands had a higher percentage of seniors living in care homes compared to other countries. However, as the government began to feel the financial burden of providing homes for its elderly, it restricted access to care homes and instead encouraged seniors to remain living in their own homes for as long as possible.

Trends

The major issue in The Netherlands has been uncoupling housing and care. Previously, housing and care were linked together, so that if an elder required some type of care he or she would be placed into either an acute care facility or a nursing home. Recently the shift has been to keep these two services independent of each other. There is now a three layered system in place:

- **Independent living**—More than 85% of seniors live in their own homes in The Netherlands. If an elder requires care he or she can access care through either a private or a public home care organization. Typically the government pays 90% of the costs and the individual pays 10%. The elder can remain living in his or her own home until the costs for home care become prohibitive for the government to continue. For example, if the elder requires help on a 24 hour basis, or cannot climb stairs but lives in an apartment that can only be accessed by stairs, then the government will either require the individual to pay for the added costs of care or require the individual to move to a sheltered home or a nursing home.

- **Sheltered housing**—A sheltered home is typically a rather luxurious apartment that has access to a number of home care services. Private enterprise builds the apartments and in return the elderly home owner sells his or her house to the company. The private firm organizes care for the elder with a nearby care home, and as such the individual has access to 24 hour surveillance and can receive care within 20 minutes if necessary. Meals and housekeeping are typical services offered. The government provides the same level of financial assistance to citizens in these homes as citizens living elsewhere.

- **Nursing homes**—These homes are hospital-like institutions where people live because the level of care required is so great that it is more efficient to have the elder living on one premise. Here care and housing become linked once again. People have all their needs met in the care homes, and little independence is required.

b) Australia

Australia is predicted to experience an increase in the proportion of its seniors relative to other age groups similar to that of other countries. Fourteen percent of the population is projected to be 65 years or older by 2006, with this will steadily increasing to 20% by 2026 (De Bellis, 1997). The current level of spending on health and welfare for the aged in Australia comprises 25-30% of

all government outlays, suggesting that future financial requirements to care for the elderly will become too burdensome on future governments (De Bellis etal, 1997).

History

In 1975, the Australian government produced a report that addressed the care of its country's seniors. The report found that expenditures were increasing rapidly mainly because of the uncontrolled growth of nursing home beds and an aging population. It also found that home care was a more cost effective method of providing assistance to seniors than nursing homes, and that 25% of all residents in nursing homes could be satisfactorily treated in their own homes.

Other studies conducted in the mid-1980's confirmed that increases in the number of nursing homes were substantially impacting expenditures. In 1962, 8.7% of the Department of Health's budget was spent on nursing homes, but by 1982 this had increased to 24.7% (De Bellis etal, 1997). The number of nursing home beds in Australia increased from 25,535 in 1963 to 74,583 by 1984, an increase of 192% (De Bellis etal, 1997). The government adopted measures to curtail the availability and the use of nursing homes for seniors.

Four approaches have been taken to housing seniors in Australia:

- **Hostels**—Hostels are an intermediate level of care between nursing homes and care in the community (Howe, 1995). They first emerged in the 1950's as facilities that provided housing but little in the way of support and care services (Howe, 1995). One of the recent initiatives for hostels has been to increase the level and the type of care offered in them (Howe, 1995). Outreach programs have also been created so that seniors not living in hostels can still access services either at their own residences or on-site at the hostel (Howe, 1995). There has been a dramatic increase in the number of hostels available for seniors. By 1990, there were 36 hostel beds available per 1,000 individuals aged +70 , and the plan is to continue increasing this ratio over the next 20 years (Howe, 1995). The physical design of hostels has changed in recent years. Hostels now consist of small clusters of units that house 8 to 10 residents each, rather than large facilities in the past that housed a larger number of residents (Howe, 1995).

- **Private Sector Retirement Housing**—Private sector retirement communities have increased in numbers over the past 15 years (Howe, 1995). While only 3-4% of all seniors live in this type of community, this figure is growing (Howe, 1995). These communities typically provide only accommodations and no social services, and receive few if any government funding for the housing (Howe, 1995). The lifestyle of the residents is geared towards recreation and socializing (Howe, 1995). In the future ,provisions will likely be made to provide social services and health care services to seniors living in retirement communities (Howe, 1995).

- **Diversification of Public Housing**—In 1987, changes were made to the Commonwealth State Housing Agreement, Australia's main instrument for government housing policy (Howe, 1995). These changes brought increased diversity to housing by allowing greater participation in the planning and management of the facilities by the public (Howe, 1995). Projects have been initiated for developing smaller, less institutional types of housing that foster greater social interaction among the residents (Howe, 1995). Community services are being provided on-site by individuals who visit the residents periodically (Howe, 1995). State housing authorities have also moved to provide small loans to home-owners so that seniors can have their homes modified to accommodate their special needs as they age (Howe, 1995).

- **Home and Community Care Program**—In 1984, the Home and Community Care Program (HACC) was established to provide comprehensive and integrated home and community care services to frail elders so that they could remain living in their own residences longer (Howe, 1995). Maintenance and renovation services are provided for such things as installing ramps and bathroom fittings (Howe, 1995). Large scale renovations and modifications are also made for individuals requiring complex care needs (Howe, 1995). The government is fully committed to the HACC program as it has increased funding for it by 95% in a 5 year period (Howe, 1995). This type of arrangement is becoming a more popular option for the government than hostels because of the increased flexibility it provides (Howe, 1995).

Conclusions

Australia's housing provisions for its seniors are undergoing change. Previously, much effort was put into linking housing with support services. The recent emphasis is to uncouple these two provisions (Howe, 1995). Care packages are being bundled in ways that provide a greater degree of flexibility to meet the needs of the frail elderly (Howe, 1995). By increasing funding for renovations and home care services, the government is attempting to reduce the number of seniors requiring state funded housing (Howe, 1995). For those who do require housing, the trend is to design smaller units or clusters where eight to ten residents can live together and meet each other's needs as best as possible (Howe, 1995).

c) Sweden

Sweden's population is greying faster than that of most other countries. Currently, 17.5% of the population is aged 65 years or older, and almost 5% are 80 years or older (Johansson 1997). Three levels of government play a role in providing for seniors' needs:

- Parliament—sets out policy aims and directives by means of legislation and economic steering measures.
- Regional county councils—bear the responsibility for health and medical care.
- Municipalities—legally obliged to meet the social services and housing requirements (Johansson 1997).

Both the regional counties and the municipalities have a high degree of autonomy to provide services for the elderly, and both have the ability to tax (Johansson 1997).

History

During the 1950's, old-age homes were the most common form of housing for the elderly who could no longer live independently (Lundin & Turner 1995). These homes were very institutional in nature, and were similar to a hospital-like setting. Some home care provisions were offered by volunteer organizations. The emphasis on old-age homes continued through the 1960's and 1970's, as the number of facilities increased in absolute and relative terms (Johansson 1997). This expansion continued until the 1980's, when growth was curtailed in favour of support services. In 1990, in order to reduce the confusion of roles and conflicting responsibilities, parliament gave the

municipalities responsibility over institutional housing and care facilities for the elderly, and also health care, which did not include medical treatment given by doctors (Johansson 1997). In effect, the government decentralized the resources and responsibilities from the regional to the local governments. Disparity exists in the level of services offered from one municipality to the next because municipalities have control over the amount and quality of the care they provide for their seniors.

The following are the types of living alternatives available to seniors:

- **Old-age homes**—Old-age homes are intended for elderly people who need constant care and support (Lundin & Turner 1995). The resident has his or her own room and washing facilities, and common areas include a dining room and living room (Lundin & Turner 1995). The average number of residents is 50 and the ratio of staff to residents is 1:3 (Lundin & Turner 1995). Nearly 8% of all persons aged 80 years and over live in old-age homes.

- **Service apartments**—Service apartments consist of one or two rooms and a kitchen, and come equipped with an alarm call system (Lundin & Turner 1995). The apartment complex contains a number of dwellings along with a restaurant and public rooms (Lundin & Turner 1995). Typically the apartments are rented under an ordinary tenancy contract (Lundin & Turner 1995). Home-help services are available to residents by the municipality on the same terms as those who remain living at home (Lundin & Turner 1995). Staff are available on a round-the-clock basis (Lundin & Turner 1995). In all, 8% of all persons over the age of 80 years live in service apartments.

- **Small-group homes**—Small-group homes are primarily for elderly who suffer from dementia (Lundin & Turner 1995). The purpose of these home is to provide a private yet collective living space that fosters a caring environment (Lundin & Turner 1995). The staff to resident ratio is 1:1, making this type of living arrangement fairly costly, thereby causing municipalities to hesitate to build them (Lundin & Turner 1995). Admission into small-group homes is determined by the municipal social services department (Lundin & Turner 1995).

- **In-home services**—The biggest trend in the housing and care of seniors is providing in-homes services so that seniors can remain living in their own homes (Lundin & Turner 1995). Home-help services consist mainly of shopping, cooking, house cleaning, clothes washing, and assisting with personal hygiene (Lundin & Turner 1995). The municipalities organize the services and subsidize their cost (Lundin & Turner 1995). Almost 20% of all those above the age of 65 years receive some type of in-home services, as do 43% over the age of 80 years (Lundin & Turner 1995).

- **Nursing homes**—Nursing homes are designed primarily for seniors who have terminal illnesses or are too frail to return to their own homes or old-age homes after receiving medical treatment (Lundin & Turner 1995).

Exhibit III-2 summarizes the type of living alternatives used persons over the ages of 65 years and 80 years (Lundin & Turner 1995).

Exhibit III-2
Elderly people receiving old-age care, Sweden, 1990

	Institutional care			Non-institutional housing with service		
	Old-age home	Long-term care[1]	Total	Small-group home	Service apartment	Home-help service
Number of person						
Age 65+	39,000	48,000	87,000	2,500	52,000	270,000
Age 80+	30,000	31,000	61,000	1,600	31,000	157,000
Percentage of persons						
Age 65+	2.6	3.1	5.7	0.2	3.4	17.7
Age 80+	8.1	8.4	16.5	0.4	8.0	43.0

Source: Data from Att bo på institution [1987], and Ålderdomshem, servichus, servicelägenheter och dagcentraler, 1990 [1991].

[1]*Estimates by inventory in 1987.*

Responsibilities, costs and charges

As stated earlier, municipalities are responsible for home-help services, old-age homes, service apartments, and most of the small-group homes (Lundin & Turner 1995). Medically-oriented long-term care and other medical care is the responsibility of the county council (Lundin & Turner 1995). The following table outlines the total costs per day for each type of alternative in US$:

- Old-age homes $75
- Small-group homes $142
- Long-term care $241
- Home-help services $30 per hour

Typically, 90% of the costs are paid for by public funding, and the resident pays the remaining 10% (Lundin & Turner 1995). Of the public funds used, 75% comes from municipal and county taxes and 25% from national taxes (Johannson 1997). Total health care spending in Sweden as a percentage of GDP has decreased to 7.5% compared to 9.5% in the 1980's (Johannson 1997).

Private providers

Experiments are underway where the private sector is being contracted to meet the needs of the elderly. Municipalities are contracting private providers for such things as dwelling maintenance, home-help service and medical care (Lundin & Turner 1995). In 1994, 4% of all provisions were provided by private companies (Johannson 1997). While this figure is relatively small, most believe that it has had a positive impact on the system because it has created an awareness of the costs of providing services, and has improved the efficiency at which public services are delivered (Johannson 1997). It is expected that private enterprise will play a larger role in the future of Sweden's care for its seniors (Lundin & Turner 1995).

d) Denmark

Currently, 15% of Denmark's population is over the age of 65 years, and by 2020 this figure is expected to increase to nearly 20% (Gottschalk 1995). For the past 15 years, the country has sought means to keep its elderly living in their own homes as long as possible. Policies have been created to separate housing functions from service functions. Consistent with this policy, nursing

homes are no longer being built (Gottschalk 1995). Older nursing homes are being converted to seniors' housing with services being provided by district nurses and home helpers (Gottschalk 1995).

Nursing homes

Nursing homes in Denmark are municipal or semi-public facilities for the very frail elderly (Gottschalk 1995). Each resident has his or her own room and bathroom, but no separate kitchen. Shared space typically includes common rooms, a dining room, and rooms for activities such as therapy and hairdressing.

The level of care in nursing homes is very high because of the frailty of the residents. The ratio of employees to residents is 95:100 (Gottschalk 1995). Staff include nurses, assistant nurses, nursing home assistants and therapists (Gottschalk 1995). All meals are served, and the elderly receive help eating, dressing and washing (Gottschalk 1995). Medical care and medication are also given (Gottschalk 1995).

Because the care received in nursing homes is so intensive, the municipality has strict guidelines for determining who is permitted access to them. Residents pay 15% of their pensions for rent in nursing homes (Gottschalk 1995). Items such as groceries, medicine, soap and hairdressing require payment in addition to the rent. Services are provided to residents by nursing home staff based on individual assessments (Gottschalk 1995).

Sheltered housing

Sheltered housing combines housing and services, but at a lesser degree than what is provided by nursing homes. They typically consist of 2 room flats with common areas and an alarm system (Gottschalk 1995). Services are provided by outside staff who take care of all elderly within a jurisdiction. Residents have tenancy agreements and pay 15% of their pensions for rent (Gottschalk 1995).

Service flats

Service flats are similar to sheltered housing and are for frail or disabled elderly who require specially designed housing because of disabilities. Services are provided by regional home-help and district nurses (Gottschalk 1995). Residents have tenancy agreements and pay 15% of their pensions for rent (Gottschalk 1995).

Services delivered to the home

Services delivered to the home have rapidly increased since the 1960's (Gottschalk 1995). This is consistent with the government's policy of trying to keep the elderly living in their own homes for as long as possible. Home help and nursing services are available 24 hours a day (Gottschalk 1995). Other services include things such as snow removal, alarm systems and meals-on-wheels (Gottschalk 1995).

The local authority assesses each individual to determine if home help and nursing services are required, and if so, the number of hours required each week (Gottschalk 1995). These services are provided free of charge (Gottschalk 1995). Most home help service is provided for less than 7 hours per week per individual, unless the recipient is extremely frail and requires more hours (Gottschalk 1995). Examples of the types of services provided by home help include cleaning, shopping, cooking and socializing.

Exhibit III-3 shows the percentage of elderly living in various housing and service arrangements by age group (Gottschalk 1995).

Exhibit III-3
Living arrangements by age, Denmark, 1987

	Age			
Living arrangements	70-74	75-79	80-84	85+
Nursing homes	2%	4%	10%	29%
Own home with home-help service	15	27	40	43
Own home without home-help service	83	69	50	28
Total	100	100	100	100

Note: Table is a rough combined estimate. Most elderly people receiving home-help service are in single-person households. The term "own home" includes ordinary housing and all kinds of special housing for the elderly except nursing homes.

Budgetary considerations

The following is a breakdown of the responsibilities attributed to caring for the elderly by each of the three levels of government in Denmark:

- **National**—responsible for state pensions, part of housing allowances, part of financing for creating new housing; 50% of the total costs attributed to seniors.

- **Municipal**—responsible for nursing homes, day-care centers, home help, district nursing, part of the housing allowance, part of the financing for new housing; 35% of the total costs attributed to seniors.

- **County**—responsible for hospitals, doctors, subsidies for medicine; 15% of the total costs attributed to seniors (Gottschalk 1995).

Previously, nursing homes were believed to be the most expensive form of care for the elderly, which helped to shape the policy of supporting seniors so that they could remain living in their own home. However, it has been learned that the costs of providing services to the elderly in nursing homes are very similar to the costs of providing the same services to those who live in their own homes (Gottschalk 1995). The major reason is the labour costs which comprise the majority of the total costs (Gottschalk 1995). This has given rise to more detailed individual assessments to determine more precisely the level of service required by an individual.

5. A Canadian experience—Ontario

Ontario is projected to have a dramatic increase in the number of seniors. In 1989, 1.2 million seniors lived the province, and by 2010 it is expected this number will grow to 1.8 million (Baker 1994). In 1989, there were 100,000 people over the age of 85 years, and by 2010 it is projected there will be 300,000 people in this category (Baker 1994). In 1990, the provincial government announced that it was going to reform the manner in which elderly and disabled persons received long-term care services (Baker 1994). The reforms were to assist a system that most believed was fragmented, inequitable and relied heavily on institutional services.

History

In 1976, the Ministry of Community and Social Services (MCSS) made its first attempts to provide supports to the elderly (Baker 1994). Funding was made available to allow seniors to receive services in their own homes. Previous to this, if a person's needs could not be met by some very basic homemaker services the senior would be moved to a nursing home or a home for the aged. In 1989, the provincial government invested $100 million to create seniors' accommodations that contained private or semi-private rooms (Baker 1994). This development was referred to as "Community Residential Alternatives" which were seen as alternatives to nursing homes (Baker 1994). Also in 1989, the Elderly Services Branch of the MCSS issued two papers that promoted "supportive independence" for seniors, and also emphasized the need to uncouple the housing component from the service component (Baker

1994). The papers included proposals to do the following: expand funding for community services, improve service coordination, provide for more community participation, reduce regional disparities, increase funding for supportive housing and provide for an integrated approach to provincial management of all long-term care health and social services (Baker 1994).

Supportive Housing Direction

Based on the recommendations arising from MCSS, a greater emphasis was placed on increasing the availability of supportive housing for the elderly. Supportive housing was to fill the gap between individuals living in their own residence and living in a long-term care facility that provided 24 hour services (Baker 1994). Consultations were held with the public to receive their input about the creation of such facilities. Seven principles were developed based on the public consultation and input from other experts (Baker 1994):

1. **Individualization**—the development of service packages that meet the needs of the consumer rather than fitting people into static programs.

2. **Flexibility**—providing elderly recipients with a choice of service options that have the ability to be changed as the elderly person's needs change.

3. **Integration**—maintaining the maximum level of assimilation, both physical and social, with the community at large.

4. **Independence**—giving individuals the freedom to live in the community with as much freedom, self-determination and responsibility as is feasible.

5. **Stability**—allowing an individual continuity in his or her physical environment and social relationships.

6. **Safety**—the component that allows residents to feel secure at all times regardless of their needs.

7. **Self-help**—supports the notion that individuals should be able to establish their own methods of receiving informal care from peers, family, or any other support network.

These principles played an integral role for creating a variety of supportive housing models.

Supportive Housing Models

The following are different types of supportive housing models:

- **Dedicated Site Model**—In this model, the occupants are all of one consumer group, for example, a senior citizens apartment building (Baker 1994). Some residents may require services while others do not. Those who do require services can access them on a 24 hour basis by some manner of emergency response or back-up service, even though they may only require a few hours of service each day (Baker 1994). Staffing is on-site.

- **Support Service Living Units**—This model encompasses a variety of set-ups ranging from a 40+ bed "mini-institution" to fully integrated units with services delivered by staff who work for a non-profit, community based board (Baker 1994). The apartments could either be clustered or spread throughout one or two buildings in a complex. Services are available 24 hours a day by on-site staff (Baker 1994).

- **Supported Independent Living Units**—These living units are targeted at individuals who require a high degree of care during the day, but can manage themselves throughout the night (Baker 1994).

- **Small Congregate Homes**—Individuals who suffer from traumatic brain injuries or degenerative diseases such as Alzheimer's disease, require intensive supervision but not necessarily extensive medical care (Baker 1994). For these people, small, segregated housing units are available (Baker 1994).

  Some general characteristics are common to all the models listed above. These include the following (Baker 1994):

  - Residents as tenants rather than clients.

  - Clustered accommodation to facilitate service delivery.

  - An integrated tenant mix that combines residents who require specific services with those require no services.

  - Accommodations integrated with the community i.e. located near shopping malls.

- Preference given to not for profit service providers.
- Support services administrative offices located off-site to minimize intrusion on tenants.
- De-linking of services provider from provider or manager of accommodations.

In order for supportive housing initiatives to work, a high degree of coordination and cooperation is necessary between the ministries of housing, health and community and social services. In the early 1990's, the provincial government committed $58 million annually to 255 supportive housing projects that served 5,500 people (Baker 1994). An additional 1,800-2,700 units were to be constructed with funding made available by the Ministry of Housing (Baker 1994).

C. A summary of national and international continuing care trends

A summary of our major findings on the national and international continuing care trends follow.

- An increasing focus on home living options—24 hour service provision, home adaptations to support resident needs and their subsequent care requirements. For example, The Netherlands supports "grow-along houses".
- A declining focus on building institutions. Clients are only admitted to facilities when their care costs in a home living environment become prohibitive. In Denmark, a moratorium on facility construction was declared and accompanied by major incentives to encourage alternative living arrangements in the community.
- A de-linking or unbundling of health, social services and housing. Service options, subject to client choice, are available independent of the housing arrangement. In the past the housing arrangement also dictated the nature of available services as they went hand in hand. This is most prevalent in The Netherlands, Denmark and Australia.
- More funding flowing to individuals and moving with individuals giving them the choice in their service selection. In the past, funding was associated with the asset rather than the individual. This strategy facilitates the unbundling of the service and housing components. For example, in the Netherlands, personalized care budgets are provided.

- An increasing array of community service providers either through public or private home care organizations, introducing an element of competition and increasing focus on quality of services. Clients have more options from which to choose, requiring informed decision making.

- An increasing reliance on the private sector for the housing component. The private sector is also expanding into the provision of health and social services. This is particularly noted in Sweden.

The international initiatives to address an aging population can have far-reaching implications for Alberta. The degree of risk taken in caring for and supporting an older population is a reflection of the population's value system. In Alberta, the degree of acceptable risk will ultimately be determined by the senior population and society at large. The issue of risk and Alberta's value system is an important consideration for the Policy Advisory Committee.

IV

Continuing Care Benchmarking Study

In this chapter we present the results of our benchmarking study. The major purpose of the benchmarking study was to identify bed planning and service planning guidelines and approaches and current utilization patterns in other provinces and selected countries. In addition, descriptive information was gathered on the programs in the three continuing care streams: facility-based, supportive living, home living. A copy of the benchmarking survey is included in Appendix D.

Five Canadian provinces were targeted: British Columbia, Saskatchewan, Manitoba, Ontario and New Brunswick. However, given other information needs, all provinces and the territories were included in the survey. Four countries were targeted: Netherlands, Denmark, Sweden and United States (state of Oregon only). Responses to our survey were received from all provinces and territories with the exception of Quebec. Internationally, responses were received from the Netherlands and Denmark.

Information obtained through the surveys was supplemented with other secondary source information obtained through other surveys and reports that had recently been completed. Each province and territory identified a contact through the Federal Provincial Working Group on Continuing Care. These individuals received a copy of the survey. Follow-up telephone contact was made to clarify and complete any missing information and data (where it was available). Internationally, contact was made through the respective KPMG international offices to elicit as much input as possible.

The most challenging aspect of the survey, and ultimately, a limitation in its utility, was the availability of current continuing care utilization information. Information systems are in various stages across Canada with few provinces having comparable statistical data readily available.

In this chapter, we provide a summary of the information collected through the survey and other secondary sources. This summary is organized by each continuing stream—home living, supportive living, continuing care centres (facility-based stream). Appendix E contains a complete compilation of all survey information.

A. Home living

All provinces have experienced a marked increase in the demand for home care services based on an increase in the seniors population, increased life expectancy, earlier discharge from hospitals, decreased budgets, etc. These pressures are forcing provinces to ensure that home care is delivered in the most efficient, cost effective manner possible.

1. Description of programs and services

All provinces provide professional services such as nursing, occupational therapy, and physical therapy through home care at no cost to the client; they are covered by provincial health care insurance programs. All provinces also have support services such as personal care and homemaking available to seniors receiving home care. However, a fee is usually charged for these services based on the client's ability to pay or a limit is placed on the number of hours of support they may receive. (Ontario limits nursing services to 4 visits per day or 28 per week, and up to 80 hours of support services in the first month and up to 60 hours per month thereafter.) In certain cases, such as end-stage palliative care clients, support services may be provided without charge (New Brunswick Extra-Mural Program). In provinces (such as Nova Scotia) where home oxygen therapy is available, clients are expected to pay a fee.

Seven provinces have client income assessment arrangements for home support services; they include British Columbia, Alberta, Saskatchewan, New Brunswick, Prince Edward Island, Nova Scotia, and Newfoundland). Quebec and Manitoba have no formal income assessment arrangements and do not charge fees, although both provinces give priority to people with no other options for care.

Saskatchewan also includes certain home maintenance provisions under the home care program, including the Saskatchewan Aids to Independent Living (SAIL) equipment, handrails, and non-skid surfaces, as well as some outdoor tasks which are essential to client safety.

In Newfoundland, clients must access services from other sources from which they may be eligible first, have a demonstrated need based on a completed assessment, have liquid assets of less than $5,000 per client or $10,000 per couple, and agree to pay a defined client contribution.

Caregiver respite is available in most areas and may be provided in home, in continuing care settings, or both. Home Care services are usually linked to other available community supports such as meals on wheels, day programs, etc.

Most provinces require clients to be referred to a higher level of care when the cost of home care exceeds that of care in a congregate facility or continuing care centre. For example, New Brunswick has specified that the maximum cost per case plan per client is $2,040 per month. Some have also determined limits by the number of hours of professional service required on a daily basis, similar to the system used in institutions.

All provinces have a system for overseeing the ongoing care of clients. The case coordinator or case manager, who is usually the assessor, is responsible for identifying care needs and monitoring service delivery on an ongoing basis. Ontario has recently adopted a new system of Community Care Access Centres (CCAC's) in which assessment, care planning and ongoing monitoring are provided by one of 43 CCAC's in the province. Services are provided by for-profit and not-for-profit providers who bid on contracts through a request-for-proposals process. Highest quality is the primary consideration and best price is the second.

PEI has a classification system with 4 levels ranging from short term (up to 30 days), medium (60-90 days), continuing (ongoing), and exceptional (e.g., palliative or care which exceeds usual budget limits).

Four models may be used to categorize home care programs in Canada (Health Canada, 1999):

- **Single entry functions** (i.e. assessment, case management and discharge planning) are delivered by public employees or staff of publicly-funded community agencies, while professional and support services are contracted out. (Ontario is currently shifting to this model.)

- **Single entry functions plus some professional services** are delivered by public employees, and some nursing services plus home support services are contracted out (Nova Scotia and Winnipeg region of Manitoba).

- **Single entry functions plus all professional services** are delivered by public employees while most support services are contracted out (e.g. New Brunswick, Newfoundland, British Columbia, and Alberta). However British Columbia is encouraging amalgamation of home support agencies with local health authorities.

- **Single entry functions, professional, and home support services** are mainly delivered by public employees (e.g. Saskatchewan, Quebec, Prince Edward Island, Yukon, and Northwest Territories).

2. Eligibility criteria

Most provinces have a standardized assessment for admission to home care, however, they vary across the country. Common criteria include:

- Resident of the province with valid health insurance.
- Safe, suitable home environment.
- Family support.
- Stable medical condition.
- Client or legal representative agreement to participate.

Anyone may refer a client for a home care assessment in all areas with the exception of the New Brunswick Extra-Mural Program which requires a physician referral.

Most provinces provide acute, short-term and long term professional services to clients over 19 years of age, with exceptions for adults with chronic debilitating conditions. Clients under age 18 may be eligible for acute home care, but are usually covered by family and social services programs if they require long term home care.

The goals of providing home care to clients tend to focus on maintaining client's independence and in allowing them to remain in their homes as long as possible, until:

- The cost of care exceeds that available in another setting such as congregate living or continuing care.
- The home living situation is deemed unsafe for the client.
- The informal support system is no longer able to continue providing care.

Alberta & Northwest Territories allow clients from other provinces to receive home care as long as they are willing to pay for the services and seek reimbursement from their home province. The waiting period for eligibility as well as type of care required for clients who have relocated from another province varies.

In New Brunswick, clients may receive long term care services at home, in congregate/supportive living, or in continuing care centres. Eligibility is based on the expectation that they will require service for more than 3 months and have at least two unmet needs in self-care (activities of daily living), self-sufficiency (behaviours of daily living), or cognitive functioning.

Most jurisdictions have self-managed care programs, with the exception of Saskatchewan, Price Edward Island, Nova Scotia and the Yukon. Quebec has the largest number of self-managed care clients (more than 6000). In Ontario, the self-managed care program is managed outside the provincial home care program, by the Centre for Independent Living in Toronto; which determines eligibility, conducts client needs assessments, and assists clients as needed to manage their own care.

Four provinces have upper limits for the cost of care which are based on the comparable cost of caring for the client in a long-term care facility (Alberta, Nova Scotia, New Brunswick, and Newfoundland).

3. Role of the family

Most provinces with the exception of the Yukon expect that family or other informal caregivers will be involved in providing care and support for clients to varying degrees. Home care generally "fills in the gaps" which exist in care of clients at home.

Some provinces expect families to be trained to deliver care which professional staff would normally provide in an institutional setting; e.g., injections. The professional staff's role becomes one of assessing the informal caregiver's willingness and ability to be taught, educating them to provide the care, and ongoing monitoring.

4. Incentives for family assistance

To date, most provinces do not have definitive criteria for reimbursing families for assisting home care clients, unless respite is considered as an incentive (BC). Alberta will pay family members to provide care in certain exceptional circumstances; e.g., in a rural area where no other qualified care provider is available.

5. Expected role of the family in funding

Families are generally not expected to assume the cost of support services for clients at home unless it is for an immediate family member, usually the spouse. Clients who live alone are generally assessed regarding the amount of the cost they will contribute based on their income and assets.

6. Role of the public sector in provision of home care

Regional health bodies have become increasingly responsible for provision of home care services in many provinces while other provinces (Nfld, NS, PEI) still have direct responsibility for home care service provision. This includes professional and support services.

New Brunswick has stated that regional offices of FCSS (Family and Community Support Services) and Mental Health are involved in professional service delivery in the home setting. In Yukon, the provincial Social Services Department has also been identified as having this responsibility.

Saskatchewan, Quebec, Prince Edward Island, Northwest Territories, and the Yukon provide professional and support services exclusively via the public system.

7. Role of the private sector in the provision of home care

Seven home care programs in the northern part of Saskatchewan are operated by the private non-profit sector. Some private firms provide professional services to individuals requesting them on a fee-for-service basis.

The private sector is involved in the delivery of professional services in Manitoba, New Brunswick, Nova Scotia, and Ontario although other provinces (Nfld, PEI) have mentioned that clients may purchase these services directly. The private sector is very involved in delivering support services in the majority of provinces. Most provinces or regional health bodies have service contracts with several private agencies including the Victorian Order of Nurses (VON). In BC in 1997-98, 28% of support services were delivered by for-profit agencies.

In most cases, clients are expected to pay for a portion of the support services they receive. Exceptions to this include Ontario which limits the number of hours of support services clients may receive (which they may supplement through a private purchase arrangement with the provider) and limited support services for acute clients provided by the New Brunswick Extra-Mural Hospital. Support Services for long term clients on home care in New Brunswick are billed to the client, while support to palliative clients usually during the end stage of their life is provided at no cost.

With regard to provision of professional services, involvement by the private sector has been the exception rather than the rule. However, there is a growing trend of greater involvement by private companies. Now that Ontario has introduced the Community Care Access Centres, all professional and support services are provided by the private sector, both for-profit and not-for-profit through a request-for-proposals process which emphasizes highest quality first and best price second.

In Winnipeg, Manitoba, there is a limited degree of contracted service provision of professional services. New Brunswick occasionally contracts for physical therapy or respiratory services when there are recruitment difficulties in the public sector. In Nova Scotia, approximately 75% of home care nursing services are provided through a provincial contract with VON Nova Scotia. Additionally, oxygen services are contracted through five vendors in Nova Scotia.

8. Staffing

Staff who provide home care services generally include:

Staff	Number of provinces
Nursing Group:	
RN's	12
RPN's	1
Nursing assistants (CAN/RNA/LPN/LNA)	7
Nursing aides/healthcare aides	6
Case managers/nurses	10
Attendant	3
Physician Group:	
Community Medicine/Public Health Physician	2
Family practitioners	12*
Geriatricians	3
Physiatrist	1
Physical medicine and rehabilitation specialists	2
Psychiatrist	1
Therapist Group:	
Ambulance attendant	2
Chiropractor	1
Dietitian	4
Nutritionist	3
Enterostomal therapist	4
Occupational therapists	11
Optometrist	1
Physiotherapist	11
Psychotherapist	1
Respiratory therapist	7
Respiratory technician	1
Speech language pathologist	4
Case manager/therapist	9
Therapist assistant (SLP)	1

Staff	Number of provinces
Others:	
Dentist	1
Dental hygienist/assistant	1
Laboratory technician	2
Pharmacist	2
Pastoral/Spiritual Counselor	1
Social worker	6
Case Manager (social work)	6
Home support/home care worker	11
Companion	3
Homemaker	9
Meals provider	10
Volunteer	8
Volunteer Manager	1

**Family physician services are provided on a fee-for-service basis, rather than as staff.*

Case managers are usually nurses in British Columbia, Alberta, Ontario, and Northwest Territories, while nurses and other professionals such as occupational therapists, physiotherapists, and social workers may be case managers in the remaining areas.

Although registered nurses are involved in providing nursing services in all provinces, registered psychiatric nurses are also involved. Licensed practical nurses also deliver care in four provinces (Saskatchewan, Manitoba, Ontario, and Nova Scotia).

As personal care has been delegated from nursing to a variety of support workers, staff training has become an important issue with many provinces developing training programs (British Columbia, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia).

9. Guidelines for planning home care services

None of the provinces mentioned specific provincial or national guidelines for planning of home care services. They appear to have been developed locally in response to demand. Provinces have realized the importance of developing reliable information systems and many are currently trying to address the issues of increased demand with limited or shrinking budgets. Reliability of information also seems to be a concern.

10. Home care settings

The majority of home care services are delivered to clients who reside in their own homes (usually over 90%). The balance is delivered to seniors or physically disabled adults who live in congregate/supportive living.

11. Innovations

Financing

In New Brunswick, The Standard Family Contribution policy was implemented in 1997 and applied to Long Term Care services in New Brunswick which includes home care. The intent is to establish a fair and equitable way of determining the level at which clients should contribute toward the cost of their services.

In PEI, a system for service measurement has been developed. This is based on the hourly cost of service which includes salary and administrative costs, benefits, service associated supplies, training and travel. For example, the basic unit of service is based on one hour of support service @ $20.00. One hour of professional service = 2 units of service or $40.00.

Also in PEI, insurance companies are providing long term care and home care insurance/investment programs in which, based on the type of program purchased, up to $100 per day could be claimed for health care services in-home or in a long term care facility. This has not become highly visible yet, but provides a planning alternative for clients.

In Saskatchewan, clients are charged $5.55 per unit of chargeable service for the first 10 chargeable units of service received in a month. (A unit is defined as one hour of service or one meal.) Chargeable units include homemaking, meals, and home maintenance services, but do not include assessment/care coordination, nursing, therapy, or volunteer services. Fees subsequent to the first 10 units are adjusted according to the client's income level with the maximum payment of $336 per month. These rates are adjusted annually in accordance with rate increases in Old Age Security and Guaranteed Income Supplements. The fees may be reduced or waived by health boards in cases of serious financial hardship.

In April, 1998, the Ontario government announced a multi-year investment plan (eight years) that will move the province forward toward a coordinated, comprehensive health system that provides a continuum of care for people consistent with their needs. This is the largest-ever expansion of health

services in Ontario; $1.2 billion will be invested to improve long-term care facility and long-term care community programs.

Technology

Technology initiatives are being developed in a number of areas:

- In Alberta, **alberta we//net** is developing new information systems to provide timely, accurate information on health—finding the best ways to use technology to link and share health information while protecting privacy.

- In BC, a health information system and an accountability framework are being developed in cooperation with the Health Authorities.

- An automated screening, assessment and care planning tool (SACPAT) has been developed and planning is in process for its implementation across Manitoba during 1999-2000. A new information database known as CSDS is being developed and will be phased in as the old system is being phased out.

- In Newfoundland, a Client and Referral Management Information System has been introduced. A new information database known as CSDS is being developed in New Brunswick and will be phased in as the old system is being phased out.

- The home care component of the Prince Edward Island System Evaluation Project is scheduled to be completed during 1998-99. It is evaluating care to those over 75 years of age, to look at services, integration and outcomes as well as validating the Continuing Care Screening Tool.

- In Quebec, release of a revised information system of client and service data (System d'information - clientele - CLSC) of software for the management of home care services is expected in the year 2000.

- The Saskatchewan Health Information Network (SHIN) is being designed to provide an integrated health information system

Streamlined assessment processes

All provinces are developing and/or reviewing standardized provincial assessment instruments and care coordination tools.

New Brunswick is currently testing the use of a more generic assessment tool that involves one assessor rather than two. Based on certain indicators, referrals are made to a second LTC partner for further or specialized assessment. This results in more efficient use of human resources. The assessment tool is being tested in electronic format Assessors use a laptop computer and upload information to the CSDS database. Client information is only recorded once, and other assessors involved with the client have access to the information.

Home care became the single point of entry to the long term care system in Alberta in 1991. Under the Long Term Care strategy introduced in 1993 in New Brunswick, the single entry assessment process was expanded to include adults under the age of 65. Other areas have followed the lead and now the single entry system has become the rule rather than the exception.

Housing

Long Term Care strategy introduced in New Brunswick in 1993 includes a residential model and alternate family living arrangements.

The Seniors Independent Housing Strategy is a federal and provincial initiative in the Northwest Territories to provide housing to seniors at no cost to enable them to remain independent for as long as possible.

Professional care

As of the year 2000, Ontario plans to contract out all professional and support services except case management.

Prince Edward Island has established a provincial geriatrician position. This position is being shared with Veteran's Affairs Canada.

Support services

A tendering process was introduced by New Brunswick in 1997 for the purchase of home support services. The purpose is to ensure consistency in both cost and quality of in-home service delivery provided by home support agencies across the province.

Other

Nova Scotia has developed a Program Risk Management Strategy.

12. International comparison

The Netherlands has an independent commission which conducts assessments for admission to home care. As in Canada, home care service is intended to supplement what the family or informal support system is able to provide for the client. The guideline for upper limit of service is not supposed to exceed 3 hours per day of care, with few exceptions. There are no incentives for family assistance in place and there is no expectation that the family will provide funding, as all costs are covered through the publicly funded system. **Denmark**, will reimburse a family member for caring for a dying relative. In Denmark, home care that is provided by municipalities and based on assessed need, supplements what the family who lives with the client, is able to provide.

The staffing profile for home care support in **The Netherlands** is much broader than that in Canada with the following **additional** groups of staff: nurse practitioners, ambulance attendants, audiologists, chiropractors, naturopaths, osteopaths, paratransport attendants, therapist assistants/activity coordinators—Recreation therapy, dentists, dental hygienists, pharmacists, social workers, alternative healers, interpreters, home support/home care workers, meals providers, volunteers, and volunteer managers.

Staffing in Denmark is not quite as broad in scope as in The Netherlands; however the same disciplines are available in congregate living and continuing care centres. The nursing group consists of registered nurses, nurses aides, and case managers. The physician group includes dermatologists, family practitioners, geriatricians, physiatrists, physical medicine and rehabilitation specialists, and psychiatrists. The therapist group includes ambulance attendants, audiologists, massage therapists, orthopticians/prostheticians, physiotherapists, radiotherapists, respiratory therapists and technicians, and speech/language pathologists. Additional staffing includes dentists and dental hygienists.assistants, denturists, X-ray technicians, laboratory technicians, and pastoral/spiritual counsellors.

Guidelines for the development of home care services in the Netherlands have not existed in the past; they have evolved in response to demand similar to the system in Canada. However, recently the Dutch government is undertaking strategies to encourage competition among companies (known as foundations) which deliver home care services to make them more cost effective. Similarly in Denmark, services have been developed by municipalities in response to identified needs.

A Care Innovation Fund has been developed in which new ideas can be tested and if successful, be incorporated into the regular system.

The Dutch government is also trying to decrease distinctions among different levels of care (similar to the seamless system concept).

B. Supportive living

1. Description of programs and services

One of the difficulties in doing a national review of home support and continuing care is the differing terminology. In some provinces, personal care homes are considered congregate/supportive living with professional care provided by home care; while in others personal care homes fall under continuing care and offer a full range of services.

Home Care provides professional service wherever congregate/supportive living facilities exist, throughout Canada. Generally, support services are provided by the facility in which the client resides.

Most provinces identify congregate/supportive living as an option for seniors. These are funded by departments other than health, with a few provinces having facilities funded by the private sector. The types and names of these programs and facilities differ. For example, New Brunswick has a program known as Alternative Family Living Arrangements (similar to foster care for children). They also provide facilities for seniors in which they have their own room or apartment and have meals, social activities, personal care, and housekeeping provided. PEI calls these Community Care Facilities.

Some provinces have municipal housing authorities responsible for congregate/supportive living as well as provision of facilities and services. Other provinces are experiencing increasing private sector involvement in ownership and management of facilities. Private sector involvement appears to be a growing trend in response to the age wave as well as increased demands for quality residential care and increased service options by seniors.

2. Eligibility criteria

In most provinces, 65 is the age which determines when a person is a senior. In the Northwest Territories, persons over 60 are considered seniors and in Nova Scotia, persons over 58 are eligible to reside in seniors housing.

In most supportive living arrangements, clients are expected to pay charges for room and board as if they are living in an apartment. Subsidies are usually available for those who cannot afford the total cost.

The Northwest Territories is the one exception in Canada where seniors housing is provided rent-free. The Seniors Independent Housing Strategy is a federal and territorial initiative to provide housing to seniors at no cost to enable them to remain independent for as long as possible.

New Brunswick has established new per diem rates for clients effective April 1, 1999; $36.00 per day for special care homes and $105.00 per day for community residences.

PEI specifies that eligibility for congregate/supportive living is based on an assessment that the individual:

- Is able to manage safely in that environment.
- Is independently ambulatory with or without ambulatory aids.
- Requires care that consists primarily of supervision, psychosocial support, and/or assistance with activities of daily living.
- Is stabilized or under clinical control if a medical condition exists.

Alberta has introduced assisted living options and described eligibility criteria to access these options.

3. Role of the family

Manitoba and Nova Scotia mentioned that families with a senior in a congregate/supportive living arrangement may be involved with decision making and some activities of daily living (ADL's) such as bill paying, shopping, etc. although this is probably common to other provinces as well. Manitoba also mentioned that families actively participate in extra curricular activities.

In Saskatchewan, family members may act as "supporters" of residents in Personal Care Homes. This means that they act as an advocate for the resident in their dealing, transactions, and relationship with the licensee.

4. Role of the public sector

Saskatchewan Municipal Affairs, Culture, and Housing funds congregate/supportive housing for individuals seeking care who need a more supportive living arrangement. Saskatchewan Health monitors and regulates Personal Care Homes. They do not subsidize the operating or capital costs of personal care homes; but they spend approximately $325,000 annually to administer the regulatory component of the legislation. This includes annual licensing, regular inspections, complaint investigations, and monitoring of personal care homes. Personal Care Homes may be licensed to accommodate up to 40 persons per facility.

5. Role of the private sector

The Personal Care Homes in Saskatchewan are one example of a role being played by the private sector. The Personal Care Homes Act was proclaimed in Saskatchewan in 1991. Personal Care Homes are privately operated and provide accommodation, meals, laundry service, and supervision/ assistance with personal care to adults not related to the operator. Personal care and health services are determined through assessment by the District Health Board. However, individuals do not have to demonstrate a need in order to be admitted to a personal care home. Residents have the same access privileges to home care and health services as other people in the province. They pay a monthly fee of between $750 and $2,500 per month based on the accommodation environment and the level of care provided. 90.6% of the residents are seniors over age 65.

6. Staffing

The staffing breakdown for congregate supportive living (based on 10 provinces which responded) is as follows:

Staff	Number of provinces
Nursing Group:	
RN's	3
CAN/RNA/LPN/LNA	2
Nurse aide/healthcare aide/resident care worker	6
Case Manager nurse	1
Attendant	5
Physician Group:	
Family Practitioner(fee for service basis)	6
Medical Geriatrician	2
Physical Medicine & Rehabilitation Specialist	1

Staff	Number of provinces
Therapist Group:	
Ambulance Attendant	1
Dietitian	1
Nutritionist	1
Occupational Therapist	4
Physiotherapist	5
Psychotherapist	1
Respiratory Therapist	2
Speech- Language Pathologist	1
Case Manager Therapist	1
Dietary Aide	1
Therapist Assistant SLP	1
Dentist	1
Dental Hygienist/Assistant	1
Pharmacist	2
Social Worker	2
Other:	
Home Support/Home Care Worker	2
Companion	2
Homemaker	3
Meals Provider	4
Volunteer	3

The New Brunswick Extra-Mural Hospital teaches caretakers in congregate/ supportive settings to provide care for clients.

7. Innovations

In 1993, New Brunswick introduced a long term care strategy which included a residential model and alternate family living arrangements.

In March 1998, Saskatchewan announced the Assisted Living Initiative which includes meals, laundry services, light and seasonal housekeeping, and a personal response system on a fee-for-service basis for tenants in senior social housing. Co-ordination of organized social and recreational activities such as transportation and tenant association activities is provided at no cost to the tenant. The delivery of these services is coordinated at the local level. This program provides a proactive approach to meet the emerging challenges of low-income seniors and persons with disabilities, integrated and coordinated responses from the housing and health

systems, and a way to deal with the aging housing tenant population with increased health needs.

8. International comparison

In **The Netherlands**, congregate/supportive living is referred to as "service assistance apartments". Home care is available as it is in Canada, while support service is provided by the management of the apartments. In **Denmark**, congregate/supportive living accommodations are independent apartments, with the residents as tenants.

Staffing

Staffing was not commented on by The Netherlands. However, since home care is provided in these settings, one could assume that many of the same staff available in homes would also be available in service assistance apartments. Some of the support staff would likely be employees of the apartments. In Denmark, the staffing is the same as for clients in their own homes.

Demand

The Netherlands is experiencing a decrease in the demand for congregate/supportive living and some of these facilities are being adapted to care for more complex clients because of the increased demand on continuing care centres. This is due to an aging population that requires higher levels of assistance.

Financing

While most health related costs are covered by national health insurance in Holland, the Dutch government appears to be moving in the direction of residents in service assistance apartments assuming responsibility for the costs of room and board. In Denmark, government funding from personal and property taxes supplements rent which residents pay.

C. Continuing care centres

1. Description of programs and services

Terminology regarding continuing care centres continues to be as varied as the number of provinces in which they exist. Names include: intermediate, multilevel, extended, private hospitals, nursing homes, personal care homes (which are sometimes included under congregate/supportive living in other provinces), and chronic care.

What differentiates continuing care from congregate/supportive living is the availability of professional staff on a 24 hour basis.

Most provinces have well developed systems in place for categorizing residents according to level of care, although the classification systems differ.

Saskatchewan provides a system of Special-care Homes that include the following services: accommodation (e.g., a safe and healthy environment, and maintenance services); care (professional nursing care, medication management, personal care, social, recreational, and pastoral services); and hotel services (food services, cleaning and sanitation services, and laundry).

2. Eligibility criteria

Clients must undergo an assessment before being admitted to continuing care and are only considered eligible when lower levels of care have been determined inappropriate. Most provinces specify a residency requirement of at least 1 year prior to admission. (BC specifies 1 year residency for intermediate level care and 3 years for extended care.) PEI stipulates that persons must be over 60 years of age.

Many provinces use a single point of entry assessment system to coordinate the process and ensure clients are cared for at the lowest appropriate level. Manitoba prioritizes clients according to urgency.

Saskatchewan has established a system of District Coordinating Committees (DCC) which provide a coordinated system for admission to Special-care Homes. Representation usually includes staff from hospitals, special-care homes, home care programs, and frequently, the housing sector. The purpose of the committees is to ensure that persons with the greatest unmet need are given first priority for special-care home admission; that people don't fall through cracks in the system; and that people receive services such as home care, respite, and day care, while waiting for placement.

Northwest Territories charges residents $712 per month to ensure that they have at least $200 of disposable monthly income remaining.

In Saskatchewan, residents of Special-care Homes pay an income-tested resident charge ranging from $783 to $1,018 per month. This represents approximately 30% of the cost of their care.

Nursing Home care is not an insured service in Nova Scotia. Residents who are able to pay the full cost of care do so. Those who are unable to cover the cost are subsidized by the Department of Health. If a resident has a spouse residing at home, the couple's income and assets are divided.

3. Role of the family

Families are not generally expected to assist with any physical care, but are more often involved with decision making and some activities of daily living such as banking, shopping. Occasionally family members in New Brunswick may be involved in the rehabilitation of relatives in nursing homes and receive direction/supervision from Extra-mural staff. Newfoundland noted that some family members chose to participate in care even though there is no requirement for them to do so.

4. Role of the public sector

Continuing care facilities in most provinces are publicly owned and operated by non-profit corporations. However, private facilities also exist in some provinces. In those cases, the provincial government adopts the role of monitoring, standards, and evaluation.

In BC, the government funds for-profit facilities at a flat rate of $8.44 per diem as of April 1998. Room differentials of $3 to $9 per day are also approved.

Twenty-two of the seventy nursing homes in Nova Scotia are operated by municipalities, and seven are operated by regional health boards or hospitals.

5. Role of the private sector

Six of the 160 Special-care Homes in Saskatchewan are operated by the private for-profit sector; another 42 are operated by the private non-profit sector. Twenty one nursing homes in Nova Scotia are operated by the non-profit sector, while 20 are for-profit.

6. Staffing

The typical staffing profile for continuing care centres in Canada (based on 10 responses) includes:

Staff	Number of provinces
Nursing Group:	
RN's	9
RPN's	4
Clinical Specialists	3
CAN/RNA/LPN/LNA	9
Nurse aide/ healthcare aide/ resident care worker	8
Case Manager nurse	4
Attendant	5
Physician Group:	
Community Medicine/ Public Health Physician	2
Dermatologist	1
Family Practitioner	9
Medical Geriatrician	4
Physiatrist	1
Physical Medicine & Rehabilitation Specialist	4
Psychiatrist	1
Resident	1
Therapist Group:	
Ambulance Attendant	2
Audiologist	1
Chiropractor	1
Dietitian	7
Nutritionist*	3
Enterostomal Therapist	3
Occupational Therapist	9
Optometrist	1
Physiotherapist	9
Psychotherapist *	1
Recreational Therapist	8
Rehabilitation Counselor	1
Respiratory Therapist*	4
Respiratory Technician	2
Speech-Language Pathologist*	3
Case Manager (Therapist)	2
Dietary Aide	6

Staff	Number of provinces
Therapist Group:	
Therapist Assistant - Physiotherapy	8
Therapist Assistant - OT	5
Therapist Assistant SLP*	2
Therapist Assistant/ Activity Coordinator Recreation Therapy	7
Dentists*	4
Dental Hygienists/Assistants	2
Denturist*	1
Others:	
Pharmacists(including 1 on contract)	5
Pastoral/ Spiritual Counsellor*	6
Social Worker	5
Case Manager (Social Work)*	4
Alternative Health - on consult in Nova Scotia	
Language Interpreter	2
Home Support/ Home Care	2
Companion	2
Homemaker	3
Meals provider	4
Volunteer	8
Volunteer Manager	3

**on consult in Nfld.*

7. Innovations

Multilevel Care Facilities—Some provinces have introduced multilevel care to make the most efficient use of staffing and programming for residents who require different levels of care.

Respite Programs—Some provinces have introduced caregiver respite in continuing care facilities, day programs, and in some cases, night programs.

Alberta is the first province in Canada to establish the CHOICE Program (Comprehensive Home Option of Integrated Care of the Elderly) which provides professional and support services to clients who reside in their homes and attend day programs but have been assessed as requiring continuing care services. They may be admitted to long term care facilities as required for respite.

8. International comparison

In **The Netherlands**, the same independent commission which is responsible for assessing clients for home care eligibility also determines what care is needed in continuing care.

In **Denmark**, individual municipalities are responsible for funding continuing care, assessing level of need, and for provision of services. The main innovation in Denmark with respect to continuing care facilities appears to be a move away from traditional nursing homes. Since 1988, the government has been building new units which treat residents as tenants and are less institutional than in the past.

D. A summary of national and international continuing care practices

A summary of our major findings on the continuing care practices across Canada and in some European countries follow.

- All provinces offer continuing care services in the three streams (facility-based, supportive living and home living) although the terminology used from one province to another varies widely, particularly in the institutional sector, reinforcing the importance of definition clarity when drawing comparisons. Of the three streams, increasing attention is being focused on the home living stream and the supportive living stream. However, the supportive living stream is the least developed and an area of growing demand.

- Eligibility criteria and service guidelines for the home living stream are fairly similar across Canada. All have age and residency requirements. Most have maximum service limits in the home living environment that when exceeded, require a reassessment for referral to a continuing care centre.

- All provide a range but standard package of professional and support services using a variety of service providers.

- Most provinces have delegated service delivery to regional health bodies. Service delivery approaches vary across the country with a higher and growing involvement of the private sector (contracted through the public sector) in the provision of support services, institutional care and other housing arrangements. In some provinces, the private/voluntary sector is involved in the delivery of professional health services such as the VON. Housing alternatives and related services are provided through a variety of government

departments, often separate from the health department and delivered through municipal government or other housing authorities.

Internationally, municipal governments may play a role in the delivery of all health and social support services, including housing.

- All provinces have developed streamlined assessment procedures and some form of classification system, although the assessment processes and classification systems vary across the country. As well, several provinces are in the process of upgrading their assessment and classification systems. Case/care management services are also provided in all provinces.

- Professional services are provided without any cost to the client. Support and housing services most often require client fees that are income and, in some cases, asset tested. The amount of fees to be paid by the client are capped.

  Internationally, clients are given the option to purchase additional services should they desire them beyond the need assessed through the public system.

- Caregiver respite is available in most provinces and includes day and night programs options, either in a community living or institutional setting. However, most provinces do not have any provisions to reimburse family members who may have extensive involvement in the care of their family members.

- Planning approaches, information systems and databases are in different stages of development across Canada so bed and service planning guidelines and specific utilization rates were largely unavailable. A specific and separate research effort to obtain utilization rates is required.

V

Continuing Care Future Scenarios Framework

In this chapter we describe a probable profile of seniors in the year 2016. We also describe the features that will likely characterize the three continuing care streams in 2016. This framework sets the stage for the future continuing care scenarios proposed and described in the subsequent chapters.

A. A profile of seniors in 2016

Alberta's senior population is growing. Overall, the senior's population is diverse with a wide range of varying needs, preferences and expectations. This diversity is an important characteristic when considering future options for caring for and supporting people as they grow older. Older seniors–those aged 85 years and older are the fastest-growing segment of the senior population and are expected to have greater needs for social support and health care.

The size of the aging population is only one dimension to be considered in developing future scenarios and is discussed more fully in the next chapter. The other characteristics of the seniors population and their implications for future continuing care services follow.

Alberta's senior population in 2016 is expected to characterized by:

More education–higher education levels resulting in more informed consumers, increased demands for more choice/options and increased capability for self managed care. While current seniors have relatively low levels of formal educational training (six out of 10 have never completed high school; 23% of females and 31% of males 65 years and older had completed some form of post-secondary education), the proportion will likely change in the future due to the current enrollment levels of the younger generation (Statistics Canada, 1996).

More income–higher income levels resulting in an increased willingness to pay for desired care and living options, also increasing the demand for a range of care and living options.

In Canada, the average income of those 65 years and older was $21,685 in 1997. The median income was $17,134. In Alberta, 35% of seniors had incomes below $14,999 in 1997 (Statistics Canada, 1997).

The proportion of seniors with low incomes has also dropped over the years. In Alberta, 15.2% of the seniors had a low income in 1996 (down from 33.7% in 1980). This group of low income seniors will have more reliance on subsidized care and living options (Statistics Canada, 1997).

Improved health–higher levels of health resulting in fewer dependencies reinforcing the demands for a range of care and living options.

Most seniors currently report their health as relatively good (in 1995, 73% of non-institutionalized and 43% of institutionalized seniors). However, seniors will continue to experience chronic conditions. In 1995, 8% of non-institutionalized seniors reported at least one condition; while 95% of institutionalized seniors reported at least one condition (Statistics Canada, 1995). The likelihood of chronic diseases will continue to rise with age.

Alzheimer's disease and other dementias will continue to be a health problem. In 1991, 8% of those 65 years and older had this disease (51% of these individuals were institutionalized. Of the institutionalized seniors, 52% were diagnosed with this condition).[4] By 2016, the number of seniors with any type of dementia could double (Canadian Study of Health and Aging, 1996).

Accommodation apart from the extended family–two parent working families, increased living distances and general job and home mobility will limit the options of older parents living with their children. However, issues related to senior/elder care will be increasingly recognized in the workplace, enabling children to take time to address their parent's needs.

In 1996, in Canada, 7% of all people aged 65 and over lived in an extended family setting, down from 11% in 1981 and 16% in 1971. In Alberta, 6% of seniors lived in an extended family setting. Older widowed women are most likely to live with extended family (Statistics Canada, 1996).

Accommodation at home–most seniors will continue to live at home. In Canada in 1996, 93% of all people aged 65 and over lived in a private household. Of these individuals, 29% lived alone. Older women (aged 85 years and older) are most likely to live alone. Twenty-nine percent of the seniors in Alberta lived alone, the same as the Canadian average.

In Alberta, in 1996, 7.8% of all seniors lived in an institution (defined as collective dwellings, including lodges). Most institutionalized seniors live in special care homes for the elderly. When lodges are excluded, about 5% of Albertans aged 65 years or older live in an institution (Alberta Health, 1998).

More active lifestyle–recreational and leisure pursuits will involve more interactive activities such as gardening, bird watching, golfing, performing arts. Interactive pursuits involving community volunteering initiatives are expected to increase. An enhanced income status will facilitate these pursuits.

More technological capabilities–the use of computers, environmental adaptations and other technological aids will enhance the capability for self managed care and independent living. As well, electronic recreational and educational pursuits will be in higher demand.

Note: The impact of other trends on the health of the senior population has not been included such as new technologies, drug therapies and increased use of personal directives and living wills.

B. Features of each continuing care stream

The features of each continuing care stream describe the characteristics underlying the continuing care scenarios. These features provide guidance in projecting the anticipated demand for each stream. Describing the features is also important in understanding the policy implications for maximizing the value to be realized through each stream. The needs and preferences being expressed by service recipients can be matched with the most appropriate service and housing options.

1. Home living stream

The home living stream is expected to experience increased demand as the population ages. The majority of older Albertans currently live in their own homes and have indicated their desire to continue to do so for as long as possible. The length of time that they are able to stay in their homes will depend on a number of factors, including their functional capacities and the available support systems and services.

Exhibit V-1
Features of the home living stream

Features	Home Living Stream
Physical structural features	• Privately owned single dwellings, individual apartments or condominiums. • Person owns/rents the property and is responsible for purchase decisions affecting the property.
Acuity	• Light to moderate physical and cognitive needs.
Service requirements	• Wide menu of service options. • Case management available. • Public services available based on assessed need. • Service scheduled. • Variety of service providers. • Increasing demands for professional and personal care and home support services. • Increasing demands for social/ recreational services. • Increasing demand for transportation • Access to respite, day care, palliative care.
Supervision and risk management	• Choice of monitoring available. • Choice of safety alert systems.
Average length of stay	• Increasing.
Availability of informal support	• More likely to have informal support.
Technological aids	• Focus on adaptive housing (may be quite costly), independent living aids, electronic monitoring.

2. Supportive living stream

The supportive living stream is experiencing increasing demand. More older adults are opting for supportive housing arrangements that may also provide options for additional health and support services that may be required as individuals age. The demand for the flexibility offered by this stream is expected to grow and, may over time, have more appeal for the emerging generation of older persons.

The supportive living stream is also characterized by the range of needs that can be accommodated and the subsequent service arrangements that can be provided. The "high end" of supportive living is typically viewed as assisted living while the "low end" is viewed as supportive housing.

The term, assisted living, is increasingly being used in housing arrangements and configurations that differ from one jurisdiction to another, creating some confusion in the marketplace. To provide some clarity, the term is described as defined in Oregon, where the concept of assisted living originated. Assisted living is a reconceptualization of long term care services for special needs populations. This reconceptualization underlies a redefinition of the role of the environment, the enhancement of care service capacity and a shift in values about how care is provided. In short, individuals receive individualized personal and/or health services in "homelike" accommodation that promotes privacy, space and dignity.

Supportive housing is more likely confined to specific tasks related to the management of the housing property and the availability of specific housekeeping services. Supportive housing is likely to include services related to personal care management or health monitoring. This type of housing and service arrangement is expected to increase.

Much of the growth in this stream is being stimulated by the private and voluntary sectors who are responding to the anticipated demand for supportive living given the changing lifestyles and preferences of the "baby boomers". The desire and demand for choice are expected to continue to propel the private and voluntary sectors.

Exhibit V-2
Features of the supportive living stream

Features	Supportive Living Stream
Physical structural features	• Smaller group living settings that facilitate a sense of community within the larger community. • Apartments with services. • Adaptable/modular units that accommodate aging in place. • Specialized group living arrangements targeting specific client groups (diagnosis, ethnicity). • Increasing ownership options. • Increasing personalization of living space.
Acuity	• Light to moderate physical and cognitive needs.
Service requirements	• Wide menu of service options that tenant chooses. • Case management available. • Public services available based on assessed need. • May be limited service providers. • Service flexibility. • Increasing demands for professional and personal care within minimal demand for home support services (latter provided through housing operator). • Increasing demands for social/recreational services. • Increasing demands for transportation to access special health and social/ recreational needs. • Access to respite, day care, palliative care.
Supervision and risk management	• Variable supervision from 24 hours per day, 7 days per week (e.g., housing operator), to on-call availability.
Average length of stay	• Increasing.
Availability of informal support	• Less likely to have informal support.
Technological aids	• Focus on adaptive housing and use of electronic monitoring aids

3. Facility-based stream

The facility-based stream refers to the system of continuing care centres that have been established throughout the province. Continuing care centres are institutional settings that provide 24 hour professional and personal support services to individuals with high physical and cognitive needs. Ownership of these centres varies from those publicly owned and operated by the Regional Health Authorities to those that are owned and operated by the private and voluntary sectors.

As other living alternatives become available, it is expected that the demand for facility-based care will stabilize over time. While a proportion of the population will experience major physical and cognitive disabilities, this proportion will likely enter continuing care centres at an older age and experience shorter lengths of stay, thus, increasing the overall through-put in the facility.

Exhibit V-3
Features of the facility-based stream

Features	Facility Living Stream
Physical structural features	• Institutional settings that focus on optimal care environment and incorporate design elements to feel more "homelike". • Provisions for acutely ill residents but not requiring acute care or those who are recuperating to enable them to remain in place. • May be specialized care units.
Acuity	• High physical and cognitive needs.
Service requirements	• High levels of professional care, 24 hours per day, 7 days a week. • Increasing levels of specialized services. • More sub acute care needs. • Increasing environmental support needs.
Supervision and risk management	• Full professional supervision, 24 hours per day, 7 days per week.
Average length of stay	• Decreasing.
Availability of informal support	• Less likely to have informal support.
Technological aids	• Focus on professional care technologies.

In the chapters that follow, we describe how the above scenarios are translated from a conceptual framework to an operational framework, using our forecasting model and methodology to predict the continuing care needs in Alberta.

VI

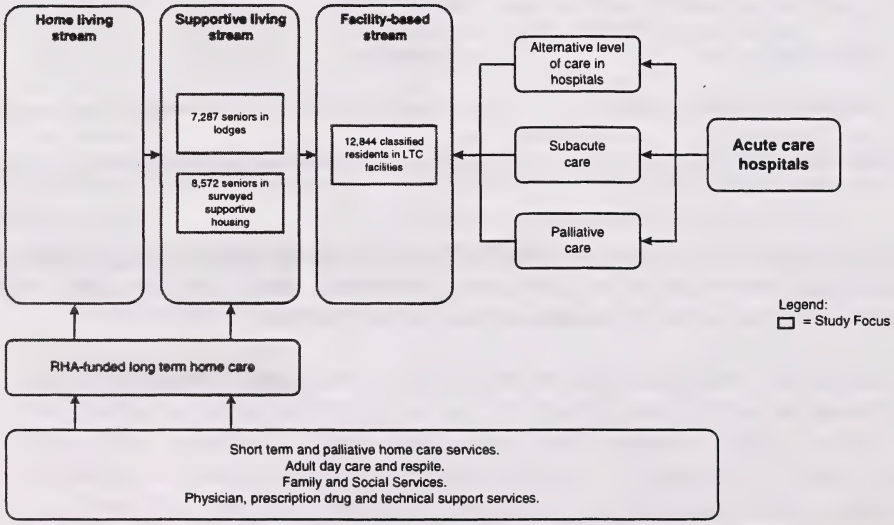
The Model

This chapter provides an overview of the methodology used to predict continuing care requirements in Alberta. We also present the population assumptions that will be used in the model.

A. Study focus

The delivery of health care services is complex in that it involves a wide range of services provided by many different providers in many different settings. Understanding the interrelationships between the various components of the continuum is a critical element in future system design. The continuum of care, as it relates to continuing care services is conceptually depicted in Exhibit VI-1.

Exhibit VI-1
Continuum of care



Our forecasting model encompasses only certain service elements that are central to the provision of continuing care services with data available at the level of detail that is required by the model. Our model therefore focuses on the provision of:

- **Facility-based services** provided by the traditional long term care or continuing care centres. As of March 31, 1998, there were 12,880 long term care beds. Residents in these beds are classified on an annual basis which formed the database that was used as a starting point in our model.

- **Supportive living services** provided by seniors lodges funded by Housing Division of Alberta Municipal Affairs and 78 for profit and not-for-profit organizations in communities with a population of greater than 10,000. Our database, therefore, is missing the provision of supportive housing units in smaller communities.

- **Long term home care services** that are funded by the Regional Health Authorities. A central database exists that is populated by the 17 Regional Health Authorities that contains the number of clients that received long term home care services during the year as well as the service volumes and dollars.

While other service components in the continuum of care have not been included in our model, we acknowledge the importance of these services as they relate to the delivery of continuing care to Albertans. Components excluded in our model include:

- Alternative level of care service provided in acute care hospitals.

- Subacute care provided in acute care centres or, in some cases, long term care centres.

- Palliative care units in both long term care facilities and acute care sites.

- Short term (i.e., less than 90 days in duration) and palliative home care services.

- Adult day hospital and day support services as well as respite services provided in long term care facilities or by community organizations.

- Home support services provided by Family and Social Services in conjunction with municipalities.

- Physician fee-for-services as well as prescription drugs and technical supports provided through Alberta Aids to Daily Living, etc.

The future scenarios built around continuing care centres, supportive living and long term home care need to be supported by appropriate adjustments, if any, to other components of the continuum of care. For example, a total of 83,860 alternative level of care days were documented in hospitals during 1997/98[1]. This translates to an equivalent of 255 beds that are used on an annual basis for this purpose. Maintaining the 1997/98 utilization rate for these services, we estimate that over 480 acute care beds would be required in 2016 for this purpose to accommodate alternative level care needs.

Similarly, a comprehensive forecast could also address the requirements for short-term and palliative care services, as well as additional long term care beds for respite, palliative and subacute purposes. A more detailed assessment on these critical elements of the continuum of care needs to occur once an agreement is achieved on the desired future continuing care scenario arising from this and related work.

B. Overview of the forecasting model

Our forecasting model is built on three key elements:

- **Population**—the number of individuals in each five-year age and gender group in Alberta.
- **Service volumes**—a measure of output or quantity of services provided to Albertans (e.g., number of residents in long term care facilities, number of clients receiving home care, etc.).
- **Utilization rate**—intensity of services provided to a given population expressed by the volume of service provided per 1,000 population.

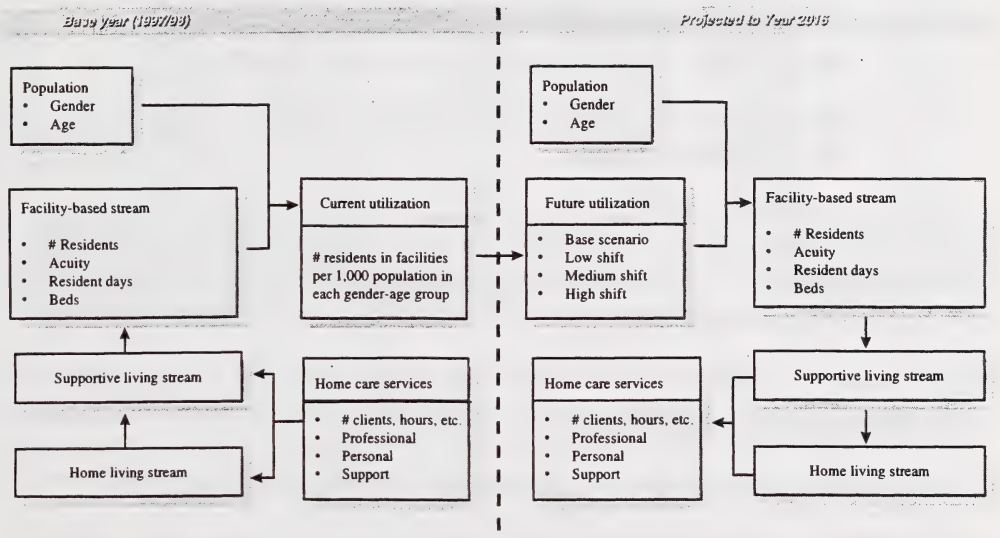
The following formula demonstrates how these three elements are combined in the model:

$$\frac{\text{Units of service volume per year provided to individuals in specific 5-year age-gender group}}{\text{Population in 5-year age-gender group}} \times 1{,}000 = \frac{\text{Service volume}}{\text{1,000 population in 5-year age-gender group}}$$

[1] *Source: CIHI Inpatient 1997/98 data.*

The model itself comprises a base year that establishes the current utilization rate of facility-based, supportive living and home care services and a future forecasting component that projects the service volumes in the various streams based on a number of utilization scenarios and the projected population. The conceptualization of this model is shown in Exhibit VI-2.

Exhibit VI-2
Forecasting model



The approach taken to model the future care scenarios starts with the facility-based services and then calculates the impact on supportive housing services and the provision of home care services based on the "shifted" number of residents from continuing care facilities. In reality, adequate supportive living and home care services will need to be in place in order to achieve the facility-based utilization scenarios by preventing and/or delaying admission to continuing care centres.

Finally, we note that home care services are provided to individuals who live in supportive living environments and individuals living in their own homes. This needs to be kept in mind to avoid confusion between the home living stream and the provision of home care services.

C. Population model assumptions

We used the medium population projection scenario that was developed by the Health Surveillance Branch within Alberta Health[1]. Key assumptions in this model included:

- Continued increase in average life expectancy from birth to 74 years in 1986 for males to 78 years in 2016. Female life expectancy will increase from 80 years to 83 years over the same period of time.

- Continuing decrease in the total fertility rate and slight increase in the mean age of fertility. Fertility rate is projected to be 1.76 in 2016.

- Net migration of 13,700 per year to Alberta by 2016. A slight decrease from the 14,200 figure in 1986.

Life expectancy from birth is expected to increase slightly. However, fertility rate will decrease by about 3.3% from the 1986 rate. We note that the fertility rate required for normal replacement is 2.1. Alberta's rate is significantly lower than this number which will contribute to an aging population.

D. Population projections

The population projection for the medium scenario is presented in Exhibit VI-3.

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[1] *Population Projections for Alberta and its Health Regions: Models and Methods, Health Surveillance, Alberta Health, Edmonton, Alberta, March 1998.*

Exhibit VI-3
Projection of population in Alberta—medium scenario

Age cohort	Year					Annual growth
	1997	2001	2006	2011	2016	
0-4	197,404	190,015	199,710	217,351	232,936	0.9%
5-9	216,517	208,071	197,378	207,489	225,087	0.2%
10-19	419,258	453,333	459,857	444,065	443,886	0.3%
20-24	190,480	210,363	244,519	258,510	252,819	1.5%
25-44	933,800	942,724	955,228	1,012,821	1,099,663	0.9%
45-64	552,642	662,997	818,657	938,522	992,362	3.1%
65-74	161,961	178,841	198,309	235,308	307,327	3.4%
75-84	90,590	103,549	122,992	140,081	156,654	2.9%
85+	27,925	33,307	40,747	49,970	60,345	4.1%
Total	2,790,577	2,983,200	3,237,397	3,504,117	3,771,079	1.6%

Source: Health Surveillance, Alberta Health, April 1998.

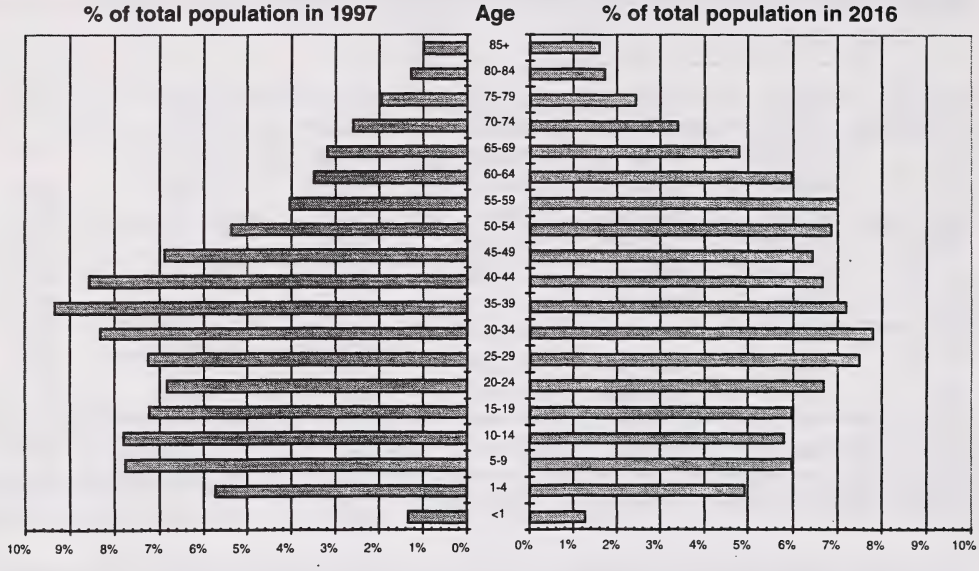
The starting point for the model used by the Health Surveillance Branch is the number of registrants in the Alberta Health Care Insurance Plan as of June 30, 1997. The population is projected to increase from 2.8 M in 1997 to 3.8 M in 2016. This represents a 35% growth in the total population over a 19 year period.

The highest annual growth rates will be seen in the older age categories. For example, the number of individuals aged 85+ will grow at an annual rate of 4.1%. Overall, the population aged 75+, the main users of continuing care services, will grow by 65%.

E. Population distribution

Exhibit VI-4 shows the percent of the population in each five-year age group in 1997 and 2016.

Exhibit VI-4
Population distribution in 2016



We will see a shift towards the older age categories. For example, the 35-39 age category accounted for over 9% of the total population in 1997. This will decrease to just over 7% in 2016. At the other extreme, individuals aged 85+ accounted for 1% of the population in 1997. This will increase to 1.5% of the total population in 2016.

VII

Facility-Based Services

This chapter presents the baseline information associated with facility-based services in 1997/98 and, describes four future scenarios for utilization of facility-based services and the resulting number of continuing care beds that would be required under each scenario.

A. Current service volume

A February 1998 survey showed that 12,844 individuals occupied beds within continuing care centres in Alberta. We note that the data represent a snapshot of a point in time. Indeed, more individuals flowed through the system when admissions, discharges and deaths are taken into account. The breakdown of continuing care facility residents by age and classification is shown in Exhibit VII-1.

Exhibit VII-1
Number of residents in long term care facilities (Alberta)

	Classification							
Age cohort	A	B	C	D	E	F	G	Total
5-9	-	-	-	-	-	1	1	2
10-19	-	-	-	-	-	3	-	3
20-24	-	-	-	-	-	6	4	10
25-44	1	5	3	13	8	78	52	160
45-64	2	57	35	61	66	238	185	644
65-74	3	169	146	176	186	509	269	1,458
75-84	19	441	342	632	758	1,532	626	4,350
85+	24	537	500	897	1,229	2,308	722	6,217
Total	49	1,209	1,026	1,779	2,247	4,675	1,859	12,844

Source: February 1998 LTC resident classification.

Younger people also reside in continuing care facilities but they account for a relatively small portion of the total residents in these facilities. About 94% of individuals residing in continuing care centres are 65 years of age or older.

B. Acuity of care

The Alberta Long Term Care Resident Classification System (ARCS) places residents in categories based on care requirements. Exhibit VII-2 provides a general description of the care characteristics associated with categories A through G.

Exhibit VII-2
Level of residential care

Classification category cluster	General description	Some characteristics
A B	Light care needs	■ Minimal or no assistance with eating, toileting, transferring or dressing. ■ General to close observation and intervention required for behaviours. ■ Occasionally incontinent to requiring management procedures for incontinence.
C D E	Medium care needs	■ No assistance to constant supervision for eating, toileting, transferring or dressing. ■ Close and constant intervention for behaviours. ■ Occasionally incontinent to requiring retraining procedures for incontinence.
F G	Heavy care needs	■ Need 2 or more people or total assistance for eating, toileting, transferring or dressing. ■ Close and constant intervention for behaviours. ■ Occasionally incontinent to requiring retraining procedures for incontinence.

Relative care requirements range from 1.0 for a category A resident to 5.18 for a category G resident. In other words, on average, a type G requires about five times more care than a typical type A resident.

Our review of the baseline information shows that only a small number of individuals classified as a category A currently reside in continuing care centres. Previous studies have shown that the acuity in continuing care centres has been increasing as existing resident care needs have increased and admissions of individuals with lower care needs have decreased. Our future care scenarios continue the trend of looking at alternative ways to meet light to medium care needs in alternative settings.

C. Comparison of utilization to other jurisdictions

We calculated the utilization of facility-based continuing care services in Alberta and compared the rate to the utilization rates in other countries as published in several sources. The results of our comparisons are shown in Exhibit VII-3.

Exhibit VII-3
Number of seniors (per 1,000 population) residing in institutions in other jurisdictions

		Age				
Country	Year	65-69	70-74	75-79	80-84	85+
Alberta	1997	6	13	32	73	223
Canada	1981	29	45	87	176	365
Austria	1992	9	22	44	83	181
Denmark	1992	10	17	37	84	240
New Zealand	1991	14	24	53	127	332
United States	1990	11	20	43	96	249

Source: Patrick Hennessy, Perspectives from a Review of OECD Countries, Paris 1995.

We note the typical utilization pattern that features significant jumps in the utilization rate in the older age categories. For example, 223 individuals aged 85+ per 1,000 individuals in that age category in Alberta currently reside in continuing care facilities or 22.3% of the population in that age category. This represents a three-fold increase in utilization from the adjacent five-year age category 80 to 84 years of age. This utilization pattern, with a gradual increase in utilization for the younger age groups towards a very steep incline in the older age categories, is typical of the utilization of a full range of health services. The need for continuing care services and/or alternatives will be particularly dramatic and sensitive to the demographic projections that clearly show an aging population.

The utilization rates in Canada were significantly higher in 1981. However, with changing technologies and the availability of alternative ways of providing services, utilization rates are considerably lower today. The difference in utilization in Canada in 1981 and Alberta in 1997 shows the different philosophy behind the provision of services to seniors in our country.

Denmark is frequently mentioned as a country that is very innovative in its approach to the provision of services to seniors. The institutional utilization rate in Denmark in 1992 is similar to the utilization rates that we currently see in Alberta. More recent data available from Denmark (January 1998) show the following institutional rates per 1,000:

- Less than one for 65 to 69 years old.
- One for 70 to 74 years old.
- Three for 75 to 79 age category.

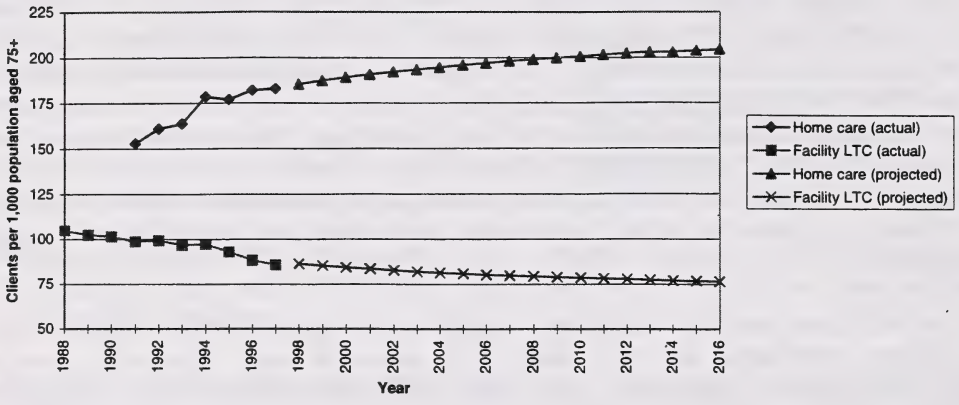
- Six for the 80 to 84 age category.
- Twelve to 41 for the 85+ age categories.

This external benchmarking information supports the continuing trend to decreasing the utilization of facility-based services in Alberta.

D. Historical utilization in Alberta

We conducted a trend analysis of utilization based on historical data going back to 1998. The utilization rate for facility-based services for individuals aged 75 and up is shown in Exhibit VII-4. Home care utilization is also provided for comparative purposes.

Exhibit VII-4
Base scenario assumptions



Utilization rate for facility-based services has fallen from about 105 per 1,000 for individuals aged 75+ in 1988 to 86 in 1997—a decrease of 18% over a nine year period. We acknowledge that some of the decrease in utilization may be the result of funding limitations that may influence the supply side of the equation. However, we were not able to determine the degree to which this impacted the utilization rate. We, however, used a variety of regression techniques to continue the trend to the year 2016 that resulted in a facility-based utilization rate of 76.4 per 1,000 for individuals aged 75+ for facility-based services. This trend is consistent with our external benchmarks as well as with our description of the typical senior in 2016.

Utilization of home care services has increased based on historical information and will continue to increase in the future. A discussion of this aspect of service will be presented in Chapter IX.

E. Future utilization scenarios

We developed four utilization scenarios for facility-based services:

- **Base scenario** that features a slight decline in facility-based utilization rate related to improved health, higher income and demand for alternatives. The utilization rate would decline about 11% over the 19 year period from 1997 to 2016. This scenario can likely be achieved with no significant changes in policies or direction from Alberta Health.
- **Scenario 1** or "low shift" scenario incorporates a further decline in the facility-based utilization rate for those individuals with light to moderate care needs (classification A to E). Scenario 1 assumes a 50% reduction in utilization rate for A's to a 30% reduction in utilization rate for E's.
- **Scenario 2** or "medium shift" scenario features a moderate decline in facility-based utilization rate for those with light to moderate care needs. This scenario assumes a 100% reduction in A's to a 60% reduction in E's.
- **Scenario 3** or "high shift" scenario features a major decline in facility-based utilization rate for those with light to moderate needs. This scenario assumes a 100% reduction in A's to an 80% reduction in E's. The major focus will be F's and G's.

Exhibit VII-5 shows the reduction of utilization rate that would occur from 1997 to 2016 for each class under each scenario.

Exhibit VII-5
Reduction in utilization rate from 1997 to 2016

Class	Base	Scenario 1	Scenario 2	Scenario 3
A	-10.8%	-50.0%	-100.0%	-100.0%
B	-10.8%	45.0%	90.0%	-95.0%
C	-10.8%	40.0%	80.0%	-90.0%
D	-10.8%	35.0%	70.0%	-85.0%
E	-10.8%	30.0%	60.0%	-80.0%
F	-10.8%	-10.8%	-10.8%	-10.8%
G	-10.8%	-10.8%	-10.8%	-10.8%

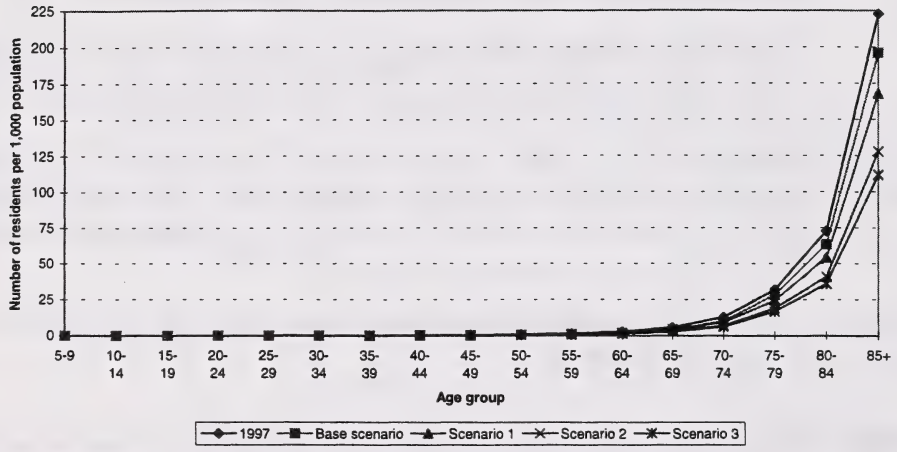
The 10.8% figure shows the rate reduction in the 75+ age categories—the highest users of the continuing care system. Utilization rates for the 65 to 74 and 0 to 64 age categories will decrease by 7.9% and 9.0% respectively.

We translated our qualitative description of seniors in the year 2016 into the model through these utilization rate scenarios.

F. Impact on utilization rates

Exhibit VII-6 shows the utilization curves that would result under each of four continuing care scenarios.

Exhibit VII-6
Facility-based utilization scenarios in 2016



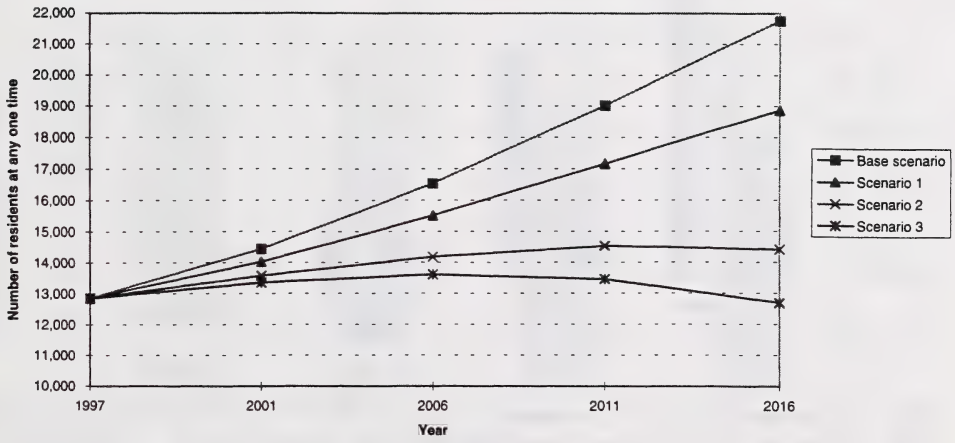
The result is that the utilization curve is pushed down with an increasing trend towards decreased utilization of facility-based services.

G. Projected services volumes

Exhibit VII-7 shows the output from our forecasting model as expressed by the number of residents that will require facility-based services in the future.

Exhibit VII-7
Projected number of facility-based residents

Scenario	1997	2001	2006	2011	2016
Base scenario	12,844	14,442	16,542	19,020	21,746
Scenario 1	12,844	14,024	15,514	17,162	18,865
Scenario 2	12,844	13,572	14,189	14,534	14,411
Scenario 3	12,844	13,355	13,604	13,451	12,685



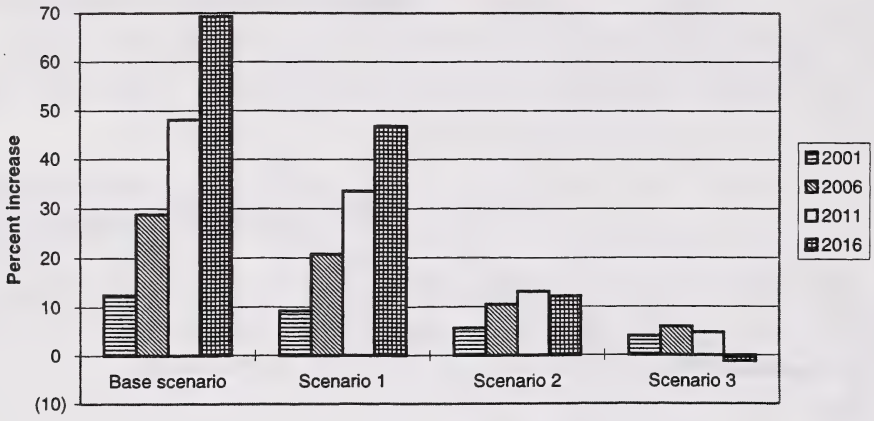
Our model shows that the following number of individuals would reside in continuing care facilities in 2016:

- 21,746 in the Base scenario—an increase of 8,902 from 1997.
- 18,865 in Scenario 1—an increase of 6,021 from 1997.
- 14, 411 in Scenario 2—an increase of 1,567 from 1997.
- 12,685 in Scenario 3—a decrease of 159 from 1997.

H. Percentage increase (decrease) in continuing care beds

Exhibit VII-8 presents our model output in terms of the percentage increase or decrease from the number of residents that were in continuing care facilities in 1997 in five year increments.

Exhibit VII-8
Percent increase in continuing care beds from 1997



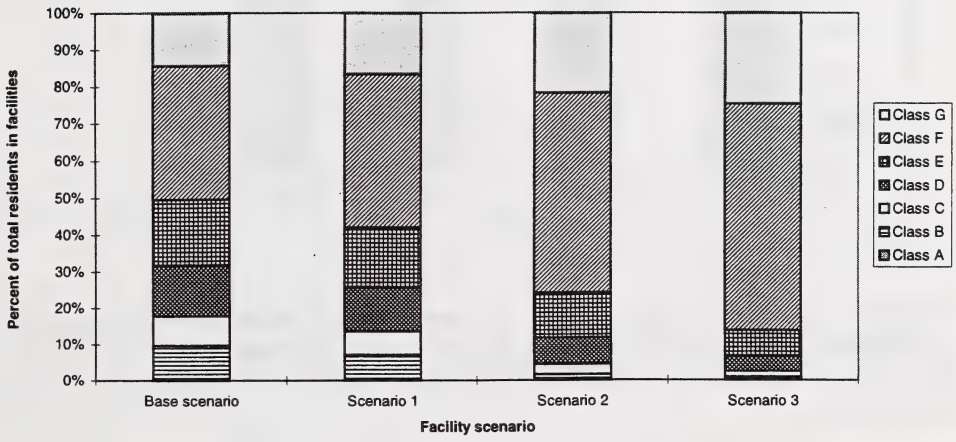
The Base scenario shows a 70% increase in beds from 1997 to 2016. This compares to a 35% growth in the total population over the same period of time. A low shift of A through E residents in Scenario 1 reduces the percent increase in continuing care beds from 70% to about 48%. Scenarios 2 and 3 further reduce the increase to the point that some beds could actually be taken out of the system in the year 2106 under Scenario 3.

The percent increase in Scenario 2 in 2016 and in Scenario 3 in 2011 and 2016 actually decreases because the decrease in utilization rate is greater than the increase in population. For example, utilization rate in some cases is increased by 70%+ from 1997. The number of individuals aged 75+ increased only 65% during the same period of time.

I. Impact on acuity

Our model was structured to decrease the utilization of lower care categories while maintaining the utilization of the higher care categories such as F's and G's. The mix of residents in continuing care facilities under each of these scenarios is summarized in Exhibit VII-9.

Exhibit VII-9
Projected facility-based acuity in 2016

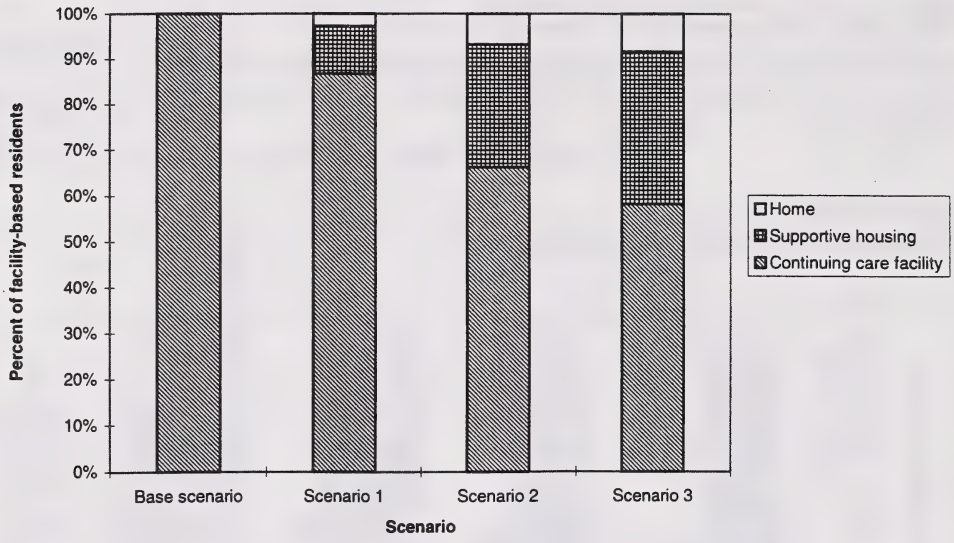


Although the number of residents in the continuing care facilities may decrease, their acuity or intensity of care would increase. The base scenario shows that about 50% of the resident population will have care requirements associated with categories A through E. This proportion decreases gradually to the point where only about 15% of residents in Scenario 3 will be classified as E or lower.

J. Alternative living arrangements

Residents in Scenarios 1 through 3 that have been "shifted" from continuing care facilities will require alternative living arrangements. We assumed that 80% of the shifted residents would live in a supportive housing situation previously described. The remaining 20% would live in their own home. Alternative living arrangements associated with Scenarios 1, 2 and 3, as compared to the 100% facility-based arrangement under the Base scenario, is shown in Exhibit VII-10.

Exhibit VII-10
Proportion of residents in alternative living arrangements in 2016



Scenarios 1 through 3 progressively increase the requirements for alternative living arrangements with supportive housing playing a very significant role in the future. In Scenario 3, for example, about 40% of individuals would reside in an alternative living arrangements.

K. Alternative level of care

Our model did not address alternative level of care (ALC) needs in acute care facilities. An equivalent of 255 beds (at 90% occupancy) were occupied for ALC purposes during 1997/98. If we assume that the utilization rate will remain at 1997/98 levels, a total of 481 ALC beds will be required in 2016. Initiatives to decrease the utilization of ALC would likely translate into additional continuing care beds.

L. Other considerations

Our model focused on projecting long term care needs. However, continuing care facilities may also be desirable sites for palliative care and subacute beds. These needs need to be addressed at the regional level.

Finally, the model projected continuing care services at a provincial level for purposes of the PAC. Actual bed numbers will vary from region to region depending on the availability of community care living option.

VIII

Supportive Living Stream

This chapter presents a description of the existing inventory of supportive housing units from available databases and projects the impact that the shift of residents from continuing care centres to alternative living arrangements will have on supportive housing.

A. Current lodge and supportive housing units

From existing databases, we were able to determine that there are 15,859 supportive housing units in Alberta. The breakdown of these units by location and lodge versus "non-lodge" is shown in Exhibit VIII-1.

Exhibit VIII-1
Number of lodges and supportive housing units in 1997/98

Location	Lodge units[1]	Supportive housing units[2]	Total
Calgary/Edmonton	2,046	7,791	9,838
Rest of Alberta	5,240	781	6,021
Total	7,287	8,572	15,859

[1] *Housing and Consumer Affairs Division, Alberta Municipal Affairs (1998).*
[2] *Supportive Housing Inventory in Communities over 10,000 (1998).*

According to the Housing and Consumer Affairs Division of Alberta Municipal Affairs, a total of 7,287 seniors lodge units exists in Alberta. The majority of these units are located outside of Edmonton and Calgary. In addition, the Alberta Municipal Affairs conducts an annual survey of supportive housing units in communities with a population of over 10,000. An additional 8,572 units are provided by facilities such as Canterbury Court and Manor in Edmonton, Camrose Care in Camrose, Chinook Village in Medicine Hat, Edith Cavell Assisted Living in Lethbridge, Edgemont in Calgary, etc.

A full listing of the organizations in the business of providing supportive housing that responded to this survey is presented in Appendix F.

The majority of the supportive housing units surveyed are located in Calgary and Edmonton. Supportive housing units do exist in smaller communities. However, databases do not exist that would allow us to accurately quantify this number.

B. Lodge care requirement profile

Exhibit VIII-2 shows the care requirements of residents currently residing in seniors lodges.

Exhibit VIII-2
Profile of residents in seniors lodges

Requirement	% of residents requiring service
Home care	56.4
Mobility aid (e.g., canes)	49.6
Medication assistance	32.4
Walker	31.7
Wheelchair	7.3
Oxygen	5.0

Source: Housing and Consumer Affairs Division, Alberta Municipal Affairs (1998). Based on a sample of 7,287 residents.

About 50% of residents in lodges currently receive home care and require assistance with mobility. About 32% receive assistance with medication. About 5% require oxygen. This profile shows that residents of seniors lodges require and receive a range of supportive services.

C. Services in other supportive housing units

Exhibit VIII-3 shows the availability of services in the 78 non-lodge supportive housing facilities in Alberta.

Exhibit VIII-3
Availability of services in supportive housing

Most common Service	% of facilities providing service
Supper/Dinner	97
Lunch	96
Outdoor/Common Area Maintenance	96
Snacks	95
Breakfast	92
Laundry Equipment	92
Social/Recreational Activities	92
Housekeeping/Maid Service	91
Assistance with Medication	90
Emergency Call System	90
Nursing Care (wound dressing, medication)	89
Emergency Nursing Care/Medical Assist	89
Room Service	87
Linen and Towel Service	86
Home Care (Help Arrange it)	86
Personal Care	85
Personal Laundry	82
Spiritual Support	82
Physiotherapy	82
Occupational Therapy	81
Palliative Care	80
Transportation	77
Pets Allowed	71

Least common Service	% of facilities providing service
Monitoring (wandering)	33
Clinics	23
Banking	19
Pharmacy	18
Footcare	14
Convenience Store	9
Podiatrist	9
Make Doctors Appointments	6
Seamstress	6
Consultations	6
Library	6
Shopping	5
Massage	5
Dry Cleaning	5
Florist	4
Postal	4
Personal Attention with Finances	1
Respite Care Room	1
Bilingual Staff	1
Milk Delivery	1
Adult Day Care	1

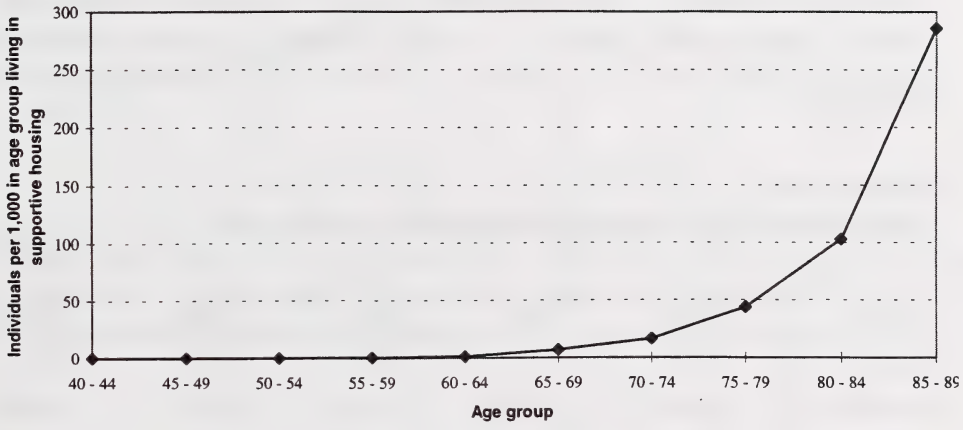
Source: Alberta Municipal Affairs, Supportive Housing Inventory in Communities over 10,000 (1998). Based on a sample size of 78 non-lodge facilities.

This exhibit shows that a wide array of services is also provided in supportive housing. Services provided in the supportive living stream will increasingly become important in our future scenarios.

D. Utilization profile

Exhibit VIII-4 shows the utilization curve for supportive housing services in Alberta. Information at the gender and age level was available only in the seniors lodges database. However, we adjusted our utilization curve to reflect the use of supportive housing in non-lodge facilities.

Exhibit VIII-4
Individuals per 1,000 in age group living in supportive housing



The graph shows a similar utilization curve with increasing utilization in the older age categories.

Utilization rate of supportive housing is about 20% to 30% higher than the utilization of continuing care centres. This utilization rate would be higher if a more complete inventory of supportive housing units was available for inclusion in the analysis.

E. Projection of supportive housing units

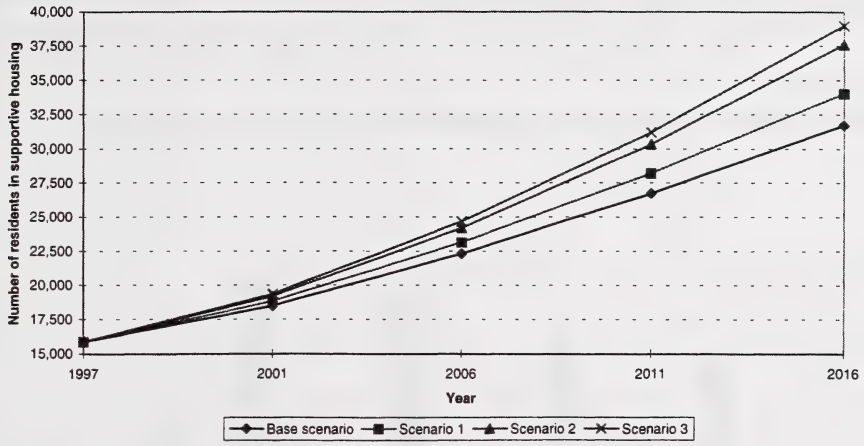
We developed a Base case scenario for supportive housing that assumed that the 1997 utilization rate would be maintained throughout the forecast period. This assumption shows that the number of supportive living units would have to increase from 15,859 in 1997 to 31,731 in 2016.

To this base, we added 80% of the clients that were shifted under the previously presented facility-based scenarios. For example, 2,881 individuals would require alternative living arrangements in Scenario 1 by 2016. About 80% of these individuals would potentially reside in a supportive living environment. As a result, the base scenario was increased by 2,304 to derive at the number of supportive housing units that would be required under Scenario 1. A similar approach was taken to determine the impact of Scenarios 2 and 3 on supportive housing units. The results are shown in Exhibit VIII-5.

Exhibit VIII-5
Projected number of occupied supportive housing units

	Year				
Scenario	1997	2001	2006	2011	2016
Base scenario	15,859	18,488	22,312	26,740	31,731
Scenario 1	15,859	18,822	23,134	28,227	34,036
Scenario 2	15,859	19,184	24,194	30,329	37,599
Scenario 3	15,859	19,357	24,662	31,195	38,980

Exhibit VIII-5 (continued)
Projected number of occupied supportive housing units

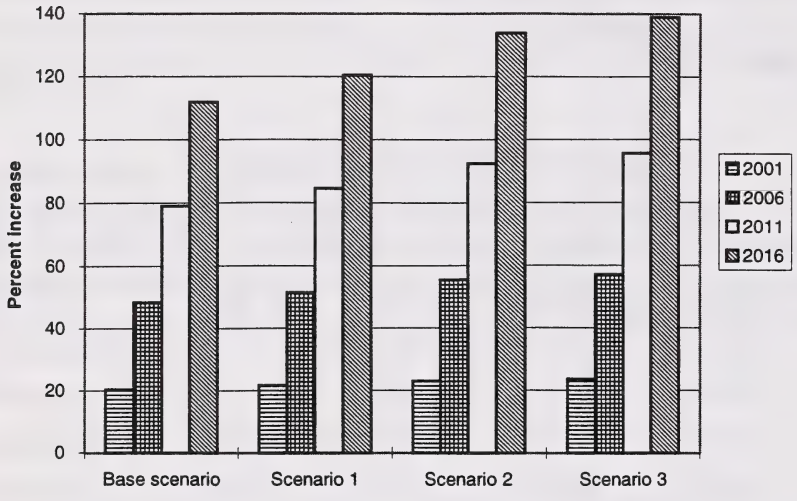


Scenario 2 shows that 5,868 additional supportive housing units will be required in 2016 (as compared to the Base scenario). Scenario 3 shows that 7,249 additional supportive housing units would be required in 2016.

F. Percent impact from 1997 level

Exhibit VIII-6 presents our forecast volume to show the percentage increase in supportive housing units from 1997 in five-year increments.

Exhibit VIII-6
Percent increase in occupied supportive housing units from 1997



Without any further pressure from continuing care facilities, the number of occupied supportive housing units will increase by 100% from 1997 in the Base scenario. In other words, the number of units will have to double from the current level.

Increased demand for alternative living arrangements under Scenarios 1, 2 and 3 will increase the growth that will be required in supportive housing units. For example, a 145% increase would be required in the year 2016 in Scenario 3 as compared to 100% in the Base scenario.

G. Concluding comments

The availability of appropriate supportive living alternatives for seniors will be a critical element to achieve the continuing care bed numbers suggested in the various scenarios. Appropriate adjustments will also need to be made to ensure that adequate home care services are available to residents in supportive housing units.

IX

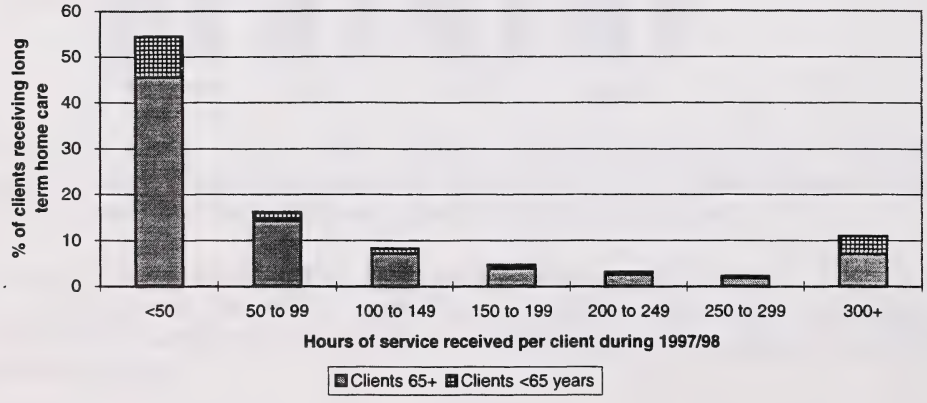
Home Care Services

This chapter provides a quantitative description of the long term home care services (i.e., those on the program for three months or longer) that were provided during 1997/98 and projects the service volumes that will be required under each of the future continuing care scenarios.

A. Volume of service provided in 1997/98

A total of 33,590 different individuals received long term home care services during 1997/98. The distribution of the number of hours of service provided to this client group during the year is presented in Exhibit IX-1.

Exhibit IX-1
Distribution of long term home care services



About 82% of the individuals that received long term home care services during the year were aged 65+. Over 50% of the clients received less than 50 hours of service during the year. At the other extreme, slightly over 10% received 300 or more hours of service during year with a significant portion of these clients less than 65 years of age.

Home care services includes services associated with assessment, home support, case coordination, direct professional care and personal care provided by RNs, LPNs, rehabilitation therapists, social workers and other staff. Statistics also include services provided under the self-managed care option where the client receives an assessed amount of money to purchase the required services.

Services do **not** include short term home care (i.e., less than 90 days in duration) and palliative home care or services provided by municipalities through Family and Social Services.

B. Intensity of services provided

Home care clients are classified using the Alberta Long Term Care Resident Classification System. The results of this classification for clients receiving home care services during 1997/98 is shown in Exhibit IX-2.

Exhibit IX-2
Classification of long term home care services during 1997/98

Class	Number of clients	Cost of service	Client service hours	$ per client per year	$ per client hour	Hours per client per year
A	10,953	13,972,922	793,472	1,276	17.61	72.4
B	12,280	21,679,087	1,313,887	1,765	16.50	107.0
C	3,559	10,860,915	741,688	3,052	14.64	208.4
D	2,267	12,130,907	848,949	5,351	14.29	374.5
E	1,826	7,453,317	517,905	4,082	14.39	283.6
F	1,095	5,031,750	354,622	4,595	14.19	323.9
G	236	918,293	64,262	3,891	14.29	272.3
Non-classified	9,205	6,158,985	345,172	669	17.84	37.5
Total	41,421	78,206,176	4,979,957	1,888	15.70	120.2

The number of clients by classification category is higher than the 33,590 discrete clients as an individual client may have been reclassified during the year. The majority of clients are classified as A or B, with decreasing numbers as the acuity increases.

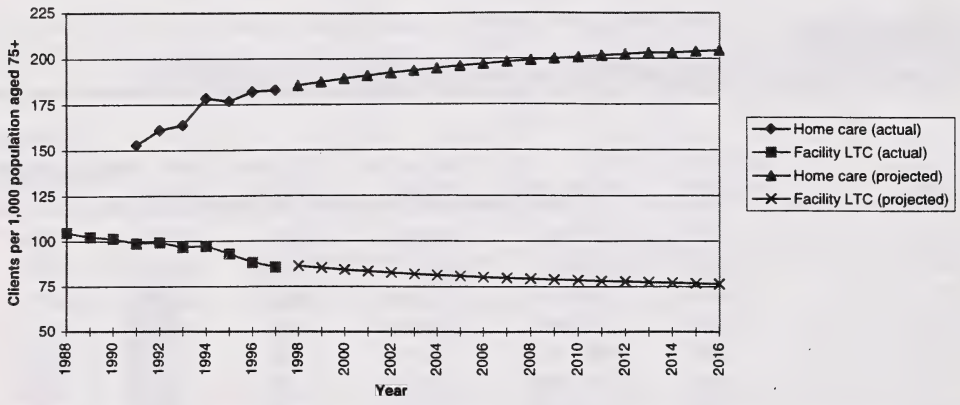
Category D clients receive the highest amount of service per year as measured by the average dollars and hours per client per year. The average dollars per client hour is highest for category A and B clients. This means that a greater portion of the services required by these clients are provided by higher paid professional staff (i.e., registered nurse).

We note that the tool used to classify home care clients was originally designed for measuring workload and acuity associated with residential care. A higher score for facility-based services may not correlate with a higher home care service need. The availability of informal supports at home also impacts the level of home care services that is required.

C. Historical utilization trend

We examined seven years of historical data from available sources in Alberta Health to help us to construct the base scenario for delivery of home care services in future. The results of the trend analysis are shown in Exhibit IX-3.

Exhibit IX-3
Base scenario assumptions



The utilization of long term home care services increased from 153 clients aged 75+ per 1,000 to 183 over the seven years of historical data. This represents an increase of 19.6% over this period of time. We used a variety of regression techniques to continue this trend into the future. The result is that home care utilization will increase to about 204 per 1,000 in 2016—an increase of 11.7% over this 19 year period. Similar techniques were used to develop the baseline utilization rates for the younger age categories. We assumed:

- A 2.2% increase in the utilization rate for the 65 to 74 age categories (i.e., 31.7 per 1,000 in 1997 to 32.4 in 2016).
- A 39.4% increase in the utilization rate for the 20 to 64 age categories (i.e., from 2.8 to 3.9 clients per 1,000).

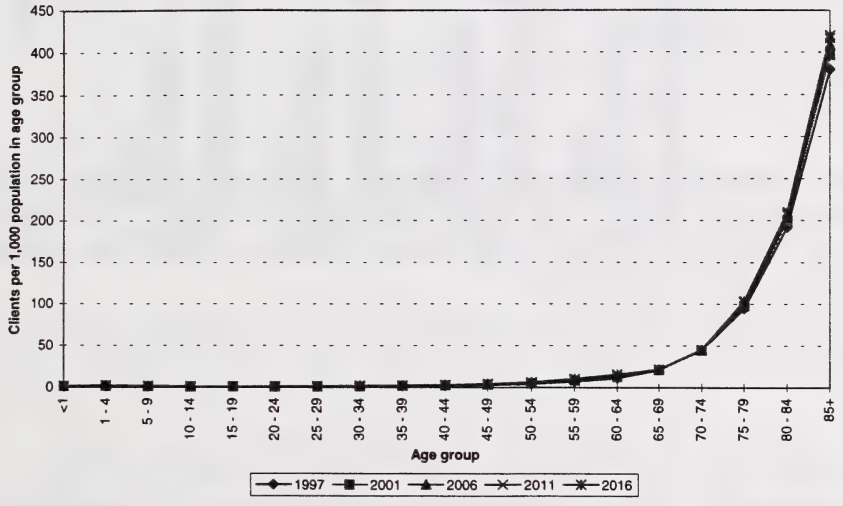
- A 45.4% increase in the utilization rate for the 0 to 19 age categories (i.e., from 1.1 to 1.6 clients per 1,000).

This became the base utilization scenario for long term home care services.

D. Utilization profile

Exhibit IX-4 shows the utilization rate for long term home care services for each five-year age grouping. As seen before, utilization rate increases as the client group ages. The impact of our base scenario utilization rates is also shown on this graph. The result is that the 1997 utilization curve is pushed upward to reflect the normal increase in home care utilization.

Exhibit IX-4
Long term home care base utilization curve

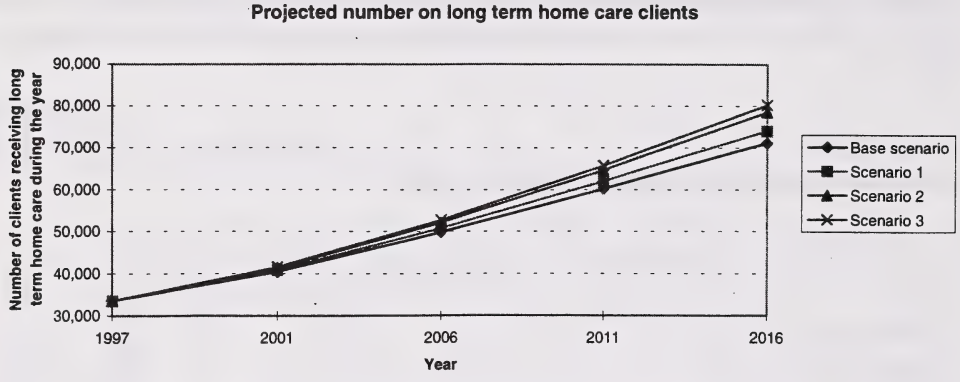


E. Projected service volume

We estimate that 71,211 individuals will require long term home care services in 2016 in the Base scenario. This represents an increase of 37,621 from the 1997 long term home care case load. Our projected volume for the Base scenario, as well as the other three scenarios, is shown in Exhibit IX-5.

Exhibit IX-5
Projected number of long term home care clients

Scenario	1997	2001	2006	2011	2016
Base scenario	33,590	40,442	49,832	60,175	71,211
Scenario 1	33,590	40,860	50,859	62,034	74,092
Scenario 2	33,590	41,312	52,184	64,662	78,546
Scenario 3	33,590	41,529	52,769	65,745	80,272

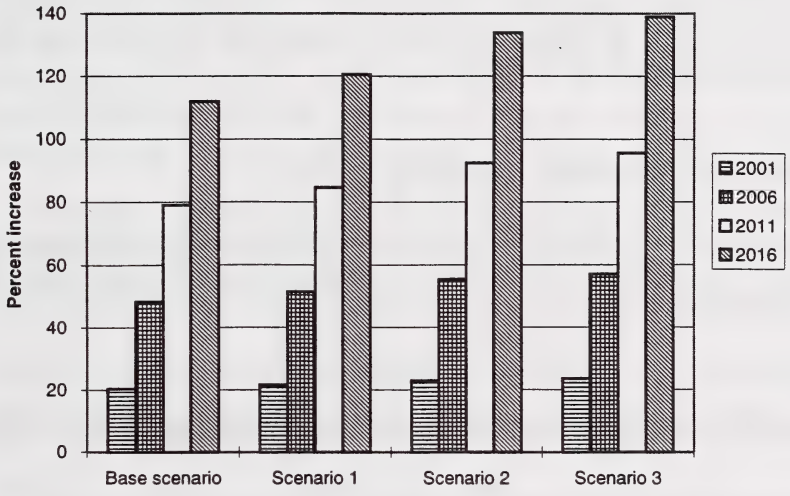


In Scenarios 1 through 3, we assume that all individuals that will be shifted from facility-based continuing care services will require some degree of home care services. Therefore, we added this difference to our baseline projection to derive the projected number of clients under these scenarios.

F. Percent increase from 1997

Exhibit IX-6 presents our home care client projection in terms of the percent increase from the 1997 case volume.

Exhibit IX-6
Percent increase in home care client from 1997



The number of clients requiring long term home care in 2016 will increase by 115% from 1997 in our Base scenario. This compares to a 35% increase in total population over the same period of time.

An increased demand will be placed for the provision of home care services to individuals that have been shifted from facility-based care to an alternative living arrangement (i.e., supportive housing or the individual's home). At the extreme, Scenario 3 will result in a 140% increase in home care clients. This compares to a 115% increase in the Base scenario.

X

Economic Impact

This chapter presents the high level analysis of the economic impact in order to illustrate the implications the future continuing care scenarios. All figures in this chapter are presented in 1998 dollars. We acknowledge that the actual costs will vary by region and depend on the economic realities at the time.

A. Alberta Health funded operating costs

Annual operating costs associated with the provision of facility-based services and home care services are shown in Exhibit X-1. Costs are shown for the 1997 base year and at four points in time in the future.

Exhibit X-1
Annual operating cost ($M) for services currently funded by Alberta Health

Scenario	1997	2001	2006	2011	2016
Facility-based services					
Base	492.2	553.2	633.7	728.7	833.1
Scenario 1	492.2	538.8	598.1	664.3	733.1
Scenario 2	492.2	523.0	551.9	572.6	577.9
Scenario 3	492.2	515.2	530.8	533.6	515.7
Home care services					
Base	97.2	117.3	144.8	175.0	206.9
Scenario 1	97.2	123.0	158.9	200.7	247.2
Scenario 2	97.2	129.6	178.0	238.5	310.9
Scenario 3	97.2	133.3	188.1	257.0	340.4
Total					
Base	589.4	670.5	778.5	903.6	1,040.0
Scenario 1	589.4	661.8	757.0	865.0	980.3
Scenario 2	589.4	652.5	729.9	811.1	888.8
Scenario 3	589.4	648.5	718.9	790.7	856.2

We assumed an Alberta Health funding rate for continuing care centres of $105 per resident day. We adjusted the care portion of the cost according to the acuity level as defined by the relative values associated with the various levels of care.

Home care costs associated with the Base scenario were calculated by applying the 1997/98 average dollar value per client per year adjusted by the acuity or intensity of care required. In addition, we included a 14% allowance to account for indirect or non-client specific costs associated with administration, travel, etc.

The incremental impact in Scenarios 2 and 3 was calculated by applying the average cost per client based on the actual six month cost experience of the Capital Health Authority in providing home-based and site-based home care services. Home based services ranged from $279 per client month for type A's to $1,306 for type E's. The provision of site based home care services (i.e., block funded services provided by the supportive housing operator) ranged from $278 per client per month for type A's to a maximum of $1,421 for type D clients. In addition, a 20% adjustment was made to account for indirect costs.

Our Base scenario shows that the annual operating costs for facility-based services will increase to over $833M in 2016 from the current $492M operating expense. Home care services will also increase in the Base scenario from $97M in 1997 to $207M in 2016. Both services will cost $1,040M in 2016 to operate under the Base scenario.

Exhibit X-2 shows a comparison of Scenarios 1 through 3 to the Base scenario operating costs.

Exhibit X-2
Increase (decrease) in annual Alberta Health funded operating costs compared to base scenario ($M)

Scenario	1997	2001	2006	2011	2016
Facility-based services					
Scenario 1	-	(14.4)	(35.6)	(64.4)	(100.0)
Scenario 2	-	(30.2)	(81.8)	(156.0)	(255.1)
Scenario 3	-	(38.0)	(102.9)	(195.0)	(317.3)
Home care					
Scenario 1	-	5.7	14.1	25.7	40.2
Scenario 2	-	12.3	33.3	63.5	104.0
Scenario 3	-	16.0	43.3	82.1	133.5
Total					
Scenario 1	-	(8.7)	(21.5)	(38.7)	(59.7)
Scenario 2	-	(17.9)	(48.5)	(92.5)	(151.2)
Scenario 3		(22.0)	(59.6)	(113.0)	(183.9)

Our analysis shows that with the decreased utilization of facility-based services, annual operating costs would be reduced by $100M to $317M per year in 2016 depending on the scenario that is chosen. Home care operating costs, on the other hand, will be $40M to $133M higher than the Base scenario home care operating costs. This is as a result of the increased client caseload associated with the individuals shifted from the facility-based stream. The net impact, however, is a reduction in Alberta Health funded costs of between $60M to $184M for Scenarios 1 to 3 respectively.

B. Impact on continuing care capital costs

Capital costs will be impacted by the number of continuing care centre beds and supportive housing units that will be required under each of the scenarios. In the Base scenario, an average of about 469 continuing care beds will need to be added to this system every year during the 19 year period of our analysis. Similarly, 835 additional supportive housing units will need to be occupied every year in our Base scenario.

Exhibit X-3
Average annual increase (decrease) to 2016

	Base scenario	Scenario 1 low shift	Scenario 2 medium shift	Scenario 3 high shift
Continuing care beds	469	317	82	(8)
Supportive housing units	835	957	1,144	1,217

Scenarios 1 through 3 show that fewer continuing care beds will need to be added due to the shift of individuals to alternative living arrangements. As a result, the number of occupied supportive housing units will need to be increased to accommodate the increased demand.

The negative number under Scenario 3 for continuing care facilities means that fewer beds will be required. However, the estimates do not include the bed requirements for respite, palliative and subacute beds, as well as beds needed to alleviate the backlog of clients waiting in acute care facilities for long term care. Consequently, the resulting scenario represents a balanced approach to the year 2016.

Exhibit X-4 shows the possible capital cost savings in each 5-year interval because fewer continuing care beds would have to be built than in our Base scenario.

Exhibit X-4
Savings in capital cost in $000s from Base scenario

Scenario	1997 to 2001	2002 to 2006	2007 to 2011	2012 to 2016	1997 to 2016
Scenario 1	(62,690)	(91,494)	(124,599)	(153,413)	(432,195)
Scenario 2	(130,491)	(222,438)	(320,070)	(427,296)	(1,100,295)
Scenario 3	(162,948)	(277,722)	(394,694)	(523,791)	(1,359,155)

Note: Costs expressed in 1998 dollars.

Capital cost of $150,000 per unit in continuing care facility.

Scenario 1 will reduce capital costs over the 19 year period by $432M as compared to the Base scenario. Scenario 3 on the other hand would reduce capital costs over this period of time by about $1.4B over the 19 year period.

C. Impact on other costs

Our economic analysis has been limited to operating and capital costs that are currently funded by Alberta Health. Additional consideration must be given to costs associated with:

- Resident co-payment in continuing care facilities.
- Individual rent and fee-for-service payments in supportive housing.
- Provincial and municipal housing subsidy payments.
- Capital cost considerations for additional supportive housing units.

The full cost picture should be considered in policy discussions surrounding who should pay for what in the future continuing care scenarios.

XI

The Preferred Continuing Care Scenarios

In this chapter we provide information on the preferred continuing care scenarios as discussed at two focus groups and a provincial workshop conducted by Alberta Health to present and discuss the proposed future continuing care scenarios. The focus groups, held in April, 1999, consisted of an Interdepartmental Focus Group, involving government officials from the former provincial departments of Health, Community Development, Family and Social Services and Municipal Affairs. The other focus group involved the Regional Health Authorities with representatives from management in the facility-based and home care service sectors. The workshop which also addressed other findings related to work being conducted by the Policy Advisory Committee, was held on June 15, 1999 and included about 150 registrants. Participants represented the Regional Health Authorities, provincial government departments and a variety of provincial organizations.

Focus group and workshop participants received a presentation on the future continuing care scenarios as described earlier in this report. They then worked in a large group (Interdepartmental Focus Group) or several small groups to discuss the preferred direction for the continuing care system and the policy implications of the particular scenario selected.

The key results from the focus groups and provincial workshop follow.

A. The Interdepartmental and Regional Health Authorities focus group results

Readers should note that the description of the scenarios for the focus groups varied from those presented at the provincial workshop. As a result of discussions arising from the focus groups, the scenarios were fine-tuned and adjusted for presentation to the provincial workshop. The final scenarios presented at the workshop were those presented earlier in this document. As a result, only a general description of the findings from the focus groups can be given.

In general, participants in the Interdepartmental Focus Group supported the medium shift scenario that saw a reduction in the number of admissions of individuals with low level needs in facilities. The scenarios strengthening supportive and home living were favored

as ones that supported consumer values, accommodated the fiscal realities and offered functional options to address a wide variety of needs and preferences. These scenarios also provide for the "unbundling" of services should this be a future policy direction and would also reduce the demand for new facility construction.

Participants in the Regional Health Authorities Focus Group worked in six small focus groups. Each group was asked to select the most likely scenario and to address any policy implications for that scenario. Again, participants showed support for a decrease in facility utilization with a major increase in supportive and home living. While some participants leaned towards a high shift scenario, others felt that such a shift needed to occur gradually.

B. The provincial workshop results

Out of eight groups, the preferences for the future scenarios were:

- **Four groups selected Scenario 3**—the "high shift" scenario that focuses on enhancing alternative living arrangements and reducing reliance on the facility-based system. This scenario was viewed as most consistent with seniors' expectations and their future preferences, as well as providing the most flexibility in the system, and at the same time assuring its affordability and sustainability. Although some expressed that Scenario 3 may be an ambitious target, most viewed the system as moving in that direction and that efforts should be made to facilitate the demands of the upcoming senior population. Even if the ultimate target is not reached, advances in this direction will be desirable.

- **Three groups selected Scenario 2**—the "medium shift" scenario that provides for more alternative living arrangements but also provides for more bed capacity in the overall system. The groups selecting this scenario felt it was more realistic with respect to the timeframe, affordability and sustainability but yet enables seniors to maintain their independence for as long as possible. This scenario was also viewed as better accommodating those with low physical and cognitive needs that may prefer assistance and socialization in a group-like living arrangement. Scenario 2 was also viewed as easing the transition to a more community based system that Scenario 3 represents in that it signals a shift in thinking and begins to prepare the service and provider system for that development. It should be noted that in one of these groups, some individuals favoured Scenario 3—most often these individuals represented the consumer perspective.

- **One group selected Scenario 1 initially, then moving to Scenario 2**—the "low shift" scenario that continues to have a major focus on the facility-based sector. This group identified a "pent-up" continuing care need in the existing system that requires increased bed capacity in the system, stressing that any new facilities need to be flexible in their design. Urban-rural differences were also cited as a factor. In addition to this scenario, the group recommended more housing and care models to accommodate individuals with early dementias and that the housing component be unbundled from the care component.

The policy implications for each of the scenarios were also discussed. The implications were categorized in three topic areas:

- **Service provision**—questions addressed changes to eligibility criteria, type of services to be offered, and human resource requirements.

- **Funding**—questions addressed the responsibility for paying for professional services, personal care and support services, housing (capital costs, housing and operating costs) and the funding of services (cost sharing/subsidy structures).

- **Legislation and standards**—questions addressed changes needed to legislation, the need to develop standards, responsibility for monitoring the system and the potential roles for the private and voluntary sectors.

A summary of the policy implications identified by participants is contained in Appendix G. Overall, the preferred direction for addressing the future needs of an aging population will require adjustments to existing policies. Future policy provisions need to allow for flexibility in the system to accommodate a wide range of needs, preferences and funding options, including potential housing partnerships offered through the private and voluntary sectors. Existing incentives and disincentives need to be addressed to enable a fair and reasonable access to the most appropriate service and housing arrangements. Information will need to be available so individuals and their families may exercise informed choices and enjoy a high quality of living as they age—living with dignity and respect. With responsive services and supportive networks, the new vision for meeting the needs of an aging population will become a reality.

Appendix A

Membership Of Policy Advisory Committee, Long Term Care Review

Appendix A

Membership Of Policy Advisory Committee, Long Term Care Review

Dave Broda*
MLA, Redwater
Chair, Long Term Care Policy Advisory Committee

Karen Kryczka
MLA, Calgary West
Vice-Chair, Long Term Care Policy Advisory Committee
Chair, Government-Wide Study on the Impact of the Aging Population
Chair, Seniors' Advisory Council for Alberta

Carl Bond
President
Alberta Long Term Care Association

Evelyn Buckley
Chair, Board of Bethany Care Society, Calgary

Mary Engelmann*
Past President
Alberta Association of Gerontology

Jean Graham*
Chair, David Thompson Regional Health Authority
Chair, Provincial Health Authorities of Alberta
Chair, Canadian Health Care Association

Dr. Peter McCracken
Past Divisional Director
Geriatric Medicine, University of Alberta

Paulette Patterson
Public representative
Business woman and former manager of senior citizens' lodge

Doug Schindeler
Retired CEO, Lethbridge Regional Hospital
Board Member, Chinook Health Region

Michael Senych
Mayor, Village of Thorhild
Chair, Newthorad Lodge Foundation

Note: *Member of the Continuing Care Future Scenarios Working Group.

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Appendix B

KPMG Consulting Team

Appendix B

KPMG Consulting Team

Carol Blair
Principal
Project Manager
Oversight and participation in all project deliverables. Assembled the characteristics of the future seniors population and the features of the continuing care streams

Mark Lazurko
Principal
Developed the forecasting methodology and resulting scenarios

Rob Elgie
Consultant
Conducted the literature review

Margaret Wanke
Wanke and Associates
Assisted with the literature review and deliberations on the conceptual model

Lynn Thoma
Private Contractor
Assisted with the benchmarking study

Appendix C

Literature Review Bibliography

Appendix C

Literature Review Bibliography

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Appendix D

Continuing Care Benchmarking Study Survey

Future Scenarios: Continuing Care Service Needs in Alberta

Benchmarking Study

Introduction: Alberta Health is undertaking a study to develop future scenarios to address the continuing care needs in Alberta to the year 2016. KPMG has been awarded the contract to conduct the study. We need to describe the bed-planning and service-planning approaches, bed and service utilization patterns and identify "best care practices" in other Canadian provinces and other countries. Your province/country has been selected to participate in the study. Would you please complete the following questions. We thank you in advance for your giving us your time and information. If you have any questions, please call or e-mail:

Carol Blair
10125 - 102 Street
Edmonton, Alberta T5J 3V8
Tel: 780-429-5863
Fax: 780-429-5850
cablair@kpmg.ca

Please return your completed survey by Monday, February 22, 1999 via fax or e-mail to Carol Blair.

Province/Country _____

Contact Person _____

Position _____

Organization _____

Telephone _____ Fax _____

E-mail _____

Definitions

Please use the following definitions when completing this survey.

Continuing care services are described in three streams:

- **Home living options**—enabling people to live independently within their own homes.

- **Congregate/supportive living environments**—supporting people to be independent in group living arrangements. Such arrangements include assisted living, seniors living accommodation (lodges, condominiums), group homes.

- **Continuing care centres**—supporting people who need 24 hour care in professional care facilities. Nursing homes, auxiliary hospitals, chronic care hospitals fall into this category.

Continuing care services are grouped into three categories:

- **Professional care**—refers to those services provided by or under the supervision of a professional service provider; e.g., nursing, personal care, rehabilitation therapy, physician.

- **Support services**—refer to those services that enable people to live comfortably and safely such as housekeeping, meals, laundry, building maintenance, seasonal cleaning.

- **Housing**—refers to the physical structure in which the client/resident resides.

A. Description of programs and services

1. Given the above streams, please describe the **programs and services that you fund** in each stream. If you are not organized around these streams please describe how you are organized and apply throughout the rest of the survey.

   Home living

   Congregate/supportive living

   Continuing care centres

B. Eligibility criteria

2. What are your **eligibility criteria** for services in each of the following streams? May we please have a copy of the eligibility criteria.

   Home living

   Congregate/supportive living

   Continuing care centres

C. The role of the family

3. The role of the family in meeting the continuing care needs of their relatives/friends is receiving more attention.

   a) With respect to family support, please describe your **policies about the level of support/care** or **expectations for assistance** from the family in each of three streams:

Home living

Congregate/supportive living

Continuing care centres

b) What **incentives** do you provide for family assistance? For example, do family members receive payment for any services that they provide?

Yes _____ , No _____. If yes, please complete the following table to describe what is reimbursed and how it is reimbursed.

What is reimbursed	How is it reimbursed

If there is a standard amount for reimbursement, please indicate what this amount is. If possible, please indicate what proportion this represents of the total public costs.

Amount: _____

% total public costs: _____

c) What is the expected role of the family in funding the following?

Professional care (i.e., user fees)

Support services (i.e., user fees)

Housing

d) What factors do you consider in determining the user fees?

D. Role of the public sector

4. What level of government is responsible for delivering services?

   a) Please check the columns that apply.

Service area	Level of Government (check the columns that apply)					
Professional care	Local/municipal		Provincial/state		National	
	Health	Other (specify)	Health	Other (specify)	Health	Other (specify)
Support services	Local/municipal		Provincial/state		National	
	Health	Other (specify)	Health	Other (specify)	Health	Other (specify)
Housing	Local/municipal		Provincial/state		National	
	Health	Other (specify)	Health	Other (specify)	Health	Other (specify)

   b) For any services that are funded through local/municipal governments, how are they funded?

   Property tax ❑

   Personal tax ❑

   Combination ❑

E. Role of private sector

5. What role has the private sector had in addressing continuing care needs?

Professional care

Support services

Housing/capital

Financing

F. Planning guidelines and utilization patterns

6. What staff is **typically employed** in the three streams. Please check all that apply.

Service provider	Home living	Congregate/ supportive living	Continuing care centres
Nursing Group: Registered Nurse			
Registered Psychiatric Nurse			
Clinical Specialist (certified/ educational designation			
CAN/RNA/LPN/LNA			
Nurse Practitioner			
Nurse Aide/Healthcare Aide/ Resident Care Workers			
Case Manager (Nurse)			
Attendant			
Physician Group: Community Medicine/Public Health Physician			
Dermatologist			
Family Practitioner			
Medical Geriatrician			
Physiatrist			
Physical Medicine & Rehabilitation Specialist			
Psychiastrist			
Resident			

Service provider	Home living	Congregate/ supportive living	Continuing care centres
Therapist Group: Ambulance Attendant			
Audiologist			
Chiropractor			
Dietitian			
Nutritionist			
Naturopath			
Enterestomal Therapist			
Kinesiologist			
Massage Therapist			
Occupational Therapist			
Optometrist			
Orthoptician/Prosthetician			
Osteopath			
Paratransport Attendant			
Physiotherapist			
Psychotherapist			
Radiotherapist			
Recreational Therapist			
Rehabilitation Counsellor			
Respiratory Therapist			
Respiratory Technician			
Speech-Language Pathologist			
Case Manager (Therapist)			
Dietary Aide			
Therapist Assistant— Physiotherapty			
Therapist Assistant— Occupational Therapy			
Therapist Assistant—Speech			

Service provider	Home living	Congregate/ supportive living	Continuing care centres
Language Pathology			
Therapist Assistant/Activity Coordinator—Recreation			
Therapy			
Dentistry Group: Dentist			
Dental Hygienist/Assistant			
Dentruist			
Technician Group: X-ray Technician			
Laboratory Technician			
Others: Educator (formally trained teachers/educators)			
Pharmacist			
Pharmacy Technician			
Psychologist			
Pastor/Spiritual Counsellor			
Social Worker			
Case Manager (Social Worker)			
Alternative Healer			
Language Interpreter			
Home Support/Home Care			
Worker			
Companion			
Homemaker			
Meals Provider			
Volunteer			
Volunteer Manager			

7. What **provincial/national guidelines** do you use for planning the number of beds or services that you will require in **continuing care centres**? Please complete the following table.

a) **Continuing care centre utilization**

Type of bed[1]	No. of beds per 1,000 population					
	Current (_____ year)			Target		
	<65	65-74	75+	<65	65-74	75+

[1]*Where possible please provide utilization numbers by type of bed i.e., traditional, transitional, respite, subacute, palliative care, alternative level of care (ALC), etc.*

Do the utilization figures provided above contain any special or significant inclusions or exclusions?

Please attach any relevant documents or studies that help to explain the above information.

b) What is your target group for facility-based care?

8. What **provincial/national guidelines** do you use for planning the numbers of **congregate/ supportive living spaces or units**. Please complete the following table.

Congregate/supportive living utilization

Type of setting[1]	No. of spaces per 1,000 population					
	Current (_____ year)			Target		
	<65	65-74	75+	<65	65-74	75+

[1] *Use definitions for settings as typically used in your jurisdiction.*

Do the utilization figures contain any special or significant inclusions or exclusions?

Please attach any relevant documents or studies that help to explain the above information.

9. Home care services

a) What **provincial/national guidelines** do you use for planning **home care services**? Please complete the following table.

Utilization of home care services

Type of service[1]	No. of discrete clients per 1,000 population					
	Current (_____ year)			Target		
	<65	65-74	75+	<65	65-74	75+

[1]*Where possible please provide utilization numbers by type of service i.e., chronic, short-term, palliative, professional, support (e.g., homemaking).*

Do the utilization figures provided above contain any special or significant inclusions or exclusions?

Please attach any relevant documents or studies that help to explain the above information.

b) Can you differentiate the setting where home care services are provided (i.e., home living vs. congregate/supportive living? Please complete the table below. Estimates are acceptable.

Current home care settings

Service type	% of clients receiving home care		
	Home setting	Congregate/ supportive living setting	Total
			100%
			100%
			100%
			100%
			100%
			100%
			100%
			100%

c) How do you differentiate home living and congregate/supportive living?

Characteristic	Home living	Congregate/supportive living
Target group		
Funding		
Other		

G. Population and aging trends

10. a) Please describe the aging trends that you have experienced and are anticipating?

Age cohorts	Current 1998	Projection 2016
0-4		
5-9		
10-19		
20-24		
25-44		
45-64		
65-74		
75-84		
85+		

b) What specific policies has the government introduced (or is planning) to address the aging issues? Please describe any strategies, policies and innovative service models to address the aging trend. Consider financing, technology, housing, professional care, support services, provider reimbursement.

H. Innovation in continuing care services

11. What would you describe as being **unique** to the continuing care services that you provide?

12. As you have introduced innovation to address the needs of your aging population, what are the **three most important lessons** that you have learned?

I. Evaluation reports and studies

13. Please indicate any available reports or studies that have been done in the last five years to address the needs of your aging population. If at all possible, please provide a copy (with invoice if necessary). If not possible, please provide a reference.

* * *

Thank you for your participation!

Appendix E

Continuing Care Benchmarking Study Results

DESCRIPTION OF PROGRAMS AND SERVICES

	Home living	Congregate/supportive living	Continuing care centres
Alberta	Professional health services including nursing; may include OT, PT, respiratory therapy, social work and case coordination. Support services may be provided through the Regional Health Authority or may be contracted to private agencies. Volunteers may also be used. Special programs include day programs, self-managed or guardian- managed care option, and care for high needs children. (There is a specialized assessment tool for these children). Home care has been the single point of entry to the long term care system since 1990.	One of the innovations in congregate living is that of lodge management bodies. Alberta has a range of congregate living options including: unique homes (usually mental health group homes), seniors lodges, group and shared homes (licensed by the Social Care Facilities Act). And seniors' supported living (in which seniors pay the full cost of health, support, and housing costs).	Nursing homes and auxiliary hospitals have been combined into what are now known as continuing care centres. This change, in addition to some new assisted living facilities, allows for seniors to age in place rather than having to be moved to higher levels of care. There are also some innovations for seniors with dementia as well as a program which is the first of its kind in Canada: CHOICE (comprehensive home option of integrated care of the elderly). This program in Edmonton allows continuing care level clients to remain at home, attend day programs, and be admitted for respite as required. There are also specialized units in continuing care facilities for short term treatment of seniors with dementia known as mentally dysfunctioning elderly units.
British Columbia	Provides accessible in-home services to elderly people and younger adults with disabilities who can no longer live independently due to health related problems. Home support services provide assistance with activities of daily living including dressing, bathing, grooming, and help with essential housekeeping tasks. Home support respite service provides relief for family caregivers. Home Nursing Care provides episodic and ongoing nursing services and is based on the self-care concept. The Community Rehabilitation Program provides direct treatment, consultation, and preventive services to clients in their homes, arranges provision of equipment required to cope with physical disabilities, and trains family members in assisting clients.	Congregate living and seniors complexes are not funded by the Ministry of Health ((MOH). The Ministry does provide services in group homes to young adults with disabilities.	Residential care facilities, intermediate, multilevel, extended, private hospitals and family care homes provide professional assistance to clients who are no longer able to remain in their own homes.
Manitoba	The Manitoba Home Care Program provides a range of nursing, personal care, and home support services to eligible residents of Manitoba. These services are aimed at helping to maintain an individual safely in their home environment, and to delay/avoid institutional placement.	Through the Manitoba Home Care Program, eligible individuals have access to group-shared environments and supportive housing environments. Such programs include the Fokus/Cluster Housing and Luther Home programs for physically disabled individuals, and supportive housing projects such as Rimmer House and Arlington Haus.	Manitoba has s system of publicly funded personal care homes (nursing homes) that offer round-the-clock nursing and personal care services for residents. Entry into a personal care home is via an application and assessment process managed jointly by Home Care and the long term care system (single entry approach). In addition, there are two long tem care hospital facilities in Winnipeg - Deer Lodge Centre and Riverview Health Centre.
New Brunswick	The New Brunswick Extra-Mural Program (EMP) provides home/community health services. They provide a small amount of contracted homemaker services, primarily for end stage palliative care. Long term care services are also provided at home under the In-Home Support Services Program	Same as for home living. There is also a program known as Alternate Family Living Arrangements, in which long term care clients may be cared for in another person's/ family's home. Residential Facilities provide non-nursing care and supervision on a 24-hour basis for Long Term Care clients who, because of their needs, are unable to continue living in their own homes. The levels of care and supervision depend upon the needs of the client and the type of facility.	Nursing homes are provided to people whose care requirements are greater than can be provided by family, and other informal or formal community care providers and residential facilities, but who do not require the level of care provided by acute care hospitals.
Newfoundland	Professional Care Services are available at home as well as Long Term Home Support Services for Seniors.	Personal Care Homes provide residential living to adults who are not able to live independently	Long term care services are provided in Nursing Homes and Health Care Centres and are designed for clients who require long term institutional care and supervision.

	Home living	Congregate/supportive living	Continuing care centres
Northwest Territories	Home care services are available to individuals living in their own home or housing units.	There are seniors lodges with home care support	Long term care is provided through facilities (like nursing homes) which provide 24 hour care for level 2,3, and 4 clients. Level 4 care is provided on extended care wards of hospitals. Level 3 - Nursing Home-Advanced physical or mental illness, requires more than assistance and supervision with activities, usually not continent, changes due to aging and chronic disease, or chronic disease, requires personal care, and may require nursing care including administration of drugs. Level 4- Extended/ Chronic Care - The level of care required by clients of all ages who require regular and continuous supervision on a 24 hour basis, and special techniques for improvement and maintenance of function.
Nova Scotia	Home Care Nova Scotia provides nursing, home oxygen, and support services.	Non-profit, rent geared to income housing is available. There are 7,500 units available for seniors.	Residential care Facilities and Homes for the aged provide Type 1 care which consists of supervision and some assistance with activities of daily living in addition to room, board and laundry services. Homes for the Aged and Licensed Nursing Homes are able to provide Type 2 care which consists of intensive personal care under the supervision of a registered nurse. Personal care may be needed on a 24 hour basis, but nursing intervention is not.

	Home living	Congregate/supportive living	Continuing care centres
Ontario	**1. Community Care Access Centres (CCAC's)** provide a simplified access point to long-term care community and facility services. CCAC's assess client's eligibility, provide service planning and case management, and purchase on behalf of eligible clients a range of services including: professional health services (nursing, physiotherapy, occupational therapy, speech and language therapy, social work and dietary services), homemaking and personal support services, medical supplies and equipment, diagnostic and laboratory services, and transportation to other medical services. CCAC's also provide information about other health services such as long term care, volunteer based community services, and supportive housing. There are 43 CCAC's in the province which are non-profit community agencies. They contract with for-profit and not-for-profit service providers in their communities through as request for proposals process. 2. **Community Support Services -** These agencies provide adult day services, meals on wheels, congregate dining, transportation services, home maintenance and repair, friendly visiting, security checks, home help, caregiver support and respite services for people who are elderly or have a physical disability or acquired brain injury. These services are delivered by non-profit agencies, primarily through volunteers. 3. **Attendant Outreach Services -** Attendant outreach services provide self-directed homemaking and personal support/ attendant services to adults with physical disabilities and acquired brain injuries. Self-Managed Attendant Service - direct funding is a program that enables eligiable adults with physical disabilities to receive funds individually to recruit, manage and pay for their own attendants.	**Supportive housing-** Supportive housing is formally defined as providing personal support services and essential homemaking in permanent, preferably not-for-profit community residential settings for frail and/or cognitively impaired elderly persons, people with physical disabilities or acquired brain injuries and those living with HIV/AIDS when service requirements justify the availability of 24 hour on-site assistance. Supportive housing will be provided in a variety of congregate housing settings and will be extended to encompass nursing and rehabilitation services in addition to personal support, homemaking services, and the availability of an emergency response system. Personal support services include: assistance with personal hygiene, assistance with activities of daily living, transferring/positioning/turning, and training of a person to carry out or assist with any of the above activities. Homemaking services include: vacuuming, shopping, meal preparation, laundry, changing bed linens, light housekeeping, banking, accompanying/assisting to do the above when the person is unable to do them independently. **Retirement Homes** - are accountable to the Ministry of Housing's Rent Control and Landlord Tenant Act under the Residents' Rights Act. There are approximately 23,000 retirement home beds across the province; average age of residents is 84.5 years and most require some level of assistance with activities of daily living. No provincial regulations govern care standards for retirement homes although the industry has some standards pertaining to quality which it self-governs. There is evidence to support the claim that where these facilities exist they serve as a direct substitute for publicly funded long term care services, and therefore affect the demand for other services.	Continuing care centres in Ontario offer 2 broad categories of programs: **Short Stay Program** which includes: **Respite Care** - which provides relief for caregivers (for up to 60 days) , and **Supportive Care** - which allows for a period of convalescence of up to 90 days. **Long Stay Program** which includes: **Homes for the Aged** -There are both charitable homes for the aged, owned and operated by private not-for-profit corporations operating under the Charitable Institutions Act, and municipal homes for the aged, owned by municipalities operating under the Homes for the Aged and Rest Homes Act. **Note: All municipalities are required by legislation to operate a home for the aged.** **Nursing Homes** regulated under the Nursing Homes Act were originally operated by for-profit organizations, including single owners and chains. Since the mid-1980's some nursing home licenses have been awarded to (and, mor recently purchased by) non-priofit organizations including hospitals and denominational and ethnic groups. Nursing homes provide primarily extended care services. The average age of residents is over 85. Individuals require assistance with activities of daily living (ADL's) and behaviours of daily living (BDL's). Many of the residents suffer from multiple conditions with over 60% suffering from some form of dementia. **Chronic hospitals** will provide very complex, technology -based care to a small number of patients with unstable conditions of technology-dependant care requirements for persons referred to as complex continuing care clients. **Complex Continuing Care** (also referred to as clinically complex care). Governed by the Public Hospitals Act, these facilities offer hospital-based care required by persons whose condition is medically unstable (i.e. fluctuates through periods of exacerbation) and/or require skilled, technology-based continuing or intermittent care. Patients who have been classified as 'clinically complex' (based on MDS/RUGS 111 methodology) have one or more of the following conditions or care requirements and are likely most appropriately cared for in a chronic hospital or unit: internal bleeding; parenteral/IV feeding; stage 4 ulcers; chemotherapy; acute medical conditions; suctioning; transfusions; lung aspirations; tube feeding; burns dialysis; tracheostomy care; ventilator; or residents meeting the criteria for the Extensive Services or Special Care categories.
Prince Edward Island	PEI Home Care Support Program provides assessment, care services, support and community liaison for people/individuals/family caregivers who would otherwise not be able to continue to remain at home or would not be able to return to home independently. PEI Respite Services include Home Care Support, some adult day program services and community liaison from Home Care to services such as Meals on Wheels, church groups, volunteer transportation, etc.	Licensed Community Care Facilities- supervised environment and some assistance with personal care and activities of daily living (i.e. Levels 1, 2, & 3.) Home Care will provide care on an intermittent or predictable basis.	There are approximately 1,000 nursing home level of care beds in the Province: 55% of these beds are provincially owned and managed. The remaining 45% are privately owned and operated. Residents are assessed for placement, as well as their ability to pay. Subsidization of the beds is available through the Welfare Assistance Act.

	Home living	Congregate/supportive living	Continuing care centres
Quebec			
Saskatchewan	The home care program was originally intorduced to Saskachewan under the aegis of the Department of Social Services in 1978 and was transferred to the Department of Health in 1983. Services provided include assessment and care coordination, nursing, homemaking, meals on wheels or wheels to meals, home maintenance, occupational and physical therapy in some districts, and volunteer services. All clients are billed a minimum of $5.55 per unit of service for the first 10 chargeable units of service per month. Chargeable units include support services and meals, and exclude professional and volunteer services. (A unit is defined as one hour of service or one meal; $55.50 minimum charge per client per month.) Beyond the basic cost, charges are assessed based on client's income. The maximum cost which a client could pay would be $336. Per month. Fees may be waived or adjusted based on hardship.	There are a range of options for individuals seeking care and who need a more supportive living arrangement. These include seniors housing through Saskatchewan Municipal Affairs, Culture, and Housing, which entails subsidized rent. Another option is personal care homes which are regulated and monitored by Saskatchewan Health. Personal care homes are operated by the private sector with no subsidies for operating or capital costs. The Department of Health allocates $325, 000 annually to administer the regulatory component of the legislation. Personal care homes provide accommodation, meals, laundry service, and supervision/assistance with personal care	Special care homes are facilities that provide 24 hour supervised, institutional, long term care services to meet the needs of individuals having heavy care needs which cannot appropriately be met in the community. District health boards may operate a special care home directly or through an affiliation or contract. Special care homes, which are sometimes referred to as nursing homes, provide an environment in which individuals can achieve and maintain as high a level of independence and life satisfaction as possible. Residents pay an income tested charge of from $783. To $1,018 per month which represents approximately 30% of the cost of their care. Services include accommodation, care (professional nursing care, medication management, personal care, social, recreational, and pastoral services), and hotel services (fpod services, cleaning and sanitation services, and laundry).
Yukon	**Note:** This page not yet received.		

PEI- Extended care beds for under 60 chronic/long term care clients are available at Prince Edward Home and some designated private nursing homes. There are approximately 80 long tern/chronic beds for the under age 60 mental health clients provided at Hillsboro Hospital for Special Care. Public/ Subsidized Housing - 1,177 units are available for seniors, with an additional 560 available for families with children. There are no group homes dedicated to seniors/continuing care programs.

Ontario- Long term- facility care. Facility settings for the provision of long term care services including medical, nursing, rehabilitative, attendant, activity, and social support services along with nutrition and shelter. (In the restructured system, long term care facilities will provide almost all institutional long term care. Long term care facilities (nursing homes/homes for the aged) receive legislative recognition in the Long term Care Statute Law Amendment Act. Under the accompanying regulations these facilities are able to provide an extensive array of technical nursing services.

ELIGIBILITY CRITERIA

	Home Living	Congregate/supportive living	Continuing care centres
Alberta	Persons must be eligible for Alberta health care or willing to pay the full cost. require a health or support service, their home must be suitable for the provision of service, home care must be the most suitable provider in terms of amount, level, and type of service required, there must be sufficient resources available, the total cost may not exceed $3,000. per month unless the client is awaiting placement, palliative, or is having an acute exacerbation of their condition which is not likely to last more than 3 months.	Generally seniors who require some assistance with activities of daily living such as homemaking and meal preparation, and/or adults with supervision requirements such as those with developmental delays or mental illnesses.	In order to be eligible for nursing homes, residents were required to have lived in Canada for 10 years and in Alberta for 12 months, or have been a resident of Alberta for 3 consecutive years during their lifetime. Since auxiliary hospitals are covered under the Canada Health Act, there is no residency requirement. However, since these 2 types of facilities have now been combined, some legislative changes need to be considered.
British Columbia	19 years of age. Canadian citizen or permanent resident. BC resident (1 year intermediate care, 3 months extended care). Have a chronic progressive condition of more than 3 months and require personal assistance.	19 years of age. Canadian citizen or landed immigrant. BC resident (1 year intermediate care, 3 years extended care. Have a chronic progressive condition of more than 3 months and require personal assistance.	Same criteria as for home living plus the client must be assessed at the Intermediate 2 Level (needing significant professional assistance) and no longer able to manage in the community.
Manitoba	Resident of Manitoba and registered with Manitoba Health Care (have a valid person health ID number). Functioning in activities essential to independent living is compromised/has declined. The provision of home care will support the client safely in their own home; will maintain or prevent deterioration in functioning essential to remain at home; will enable family caregivers to maintain their role in supporting the client at home; and care services required to support the client are not available through family caregivers, community and other programs and resources.	Individuals 65 years and over who are frail and/or cognitively impaired, who require ongoing personal support and homemaking services, whose care needs are beyond the capacity of the provincial Home Care Program. Individuals under age 65 who meet the above criteria and who are not eligible for services from other government programs. Adults under 65 with physical disabilities or other long term care conditions who require personal support services and homemaking on a continuing basis in order to remain in the community and whose care needs extend beyond the capacity of the existing Home Care Program.	Beyond the care capacity of community care/home care systems, approved as eligible by Manitoba Assessment and Placement Process (MAPP), prioritized according to urgency.
New Brunswick	NB resident with valid NB medicare card (or have applied for one). Have a need which requires the services of one of the professionals. Suitable home environment & support if necessary. Physician referral except for rehab services. Stable medical condition. Client consent. Certain specific eligibility requirements for some programs (i.e. oxygen).	Same as for home.	Note: Long term care services may be provided at home, in congregate/supportive living or in Continuing care centres. Eligibility is determined by the expectation that the client's condition will remain fairly stable or decline over months and years, they will require service for more than 3 months, and they have at least 2 unmet needs obtained from Self-Care (ADL), Self-Sufficiency (IADL) or cognitive dimensions.
Newfoundland	For Professional Care Services, clients must be covered by the provincial Medicare Plan (MCP), be assessed as having a need which can be met through Continuing Care, be willing to have the services provided at home and actively participate in the care plan, have a safe and suitable home environment, and have a physician who will provide medical orders for treatments and follow-up as required. For Long Term Home Support for Seniors, clients must be 65 years of age or older, access services from other sources for which they may be eligible first, have demonstrated need, have liquid assets of less than $5,000 for an individual or $10,000 for a couple, undergo a financial assessment, and agree to pay the defined client contribution before a home support subsidy is approved.	Clients accessing Personal Care Homes have a level of care/need which in future the family or other community resources will be unable to meet; and are assessed as requiring the level of care for which the personal care home is registered and approved.	Clients accessing Nursing Homes and Health Care Centres have a medical condition which is stable, have assessed needs that require 24 hour professional services, have a level of care/need which in future the family or other community resources will be unable to meet, or are in a personal care home and assessed to have needs beyond the scope of that program, or are medically discharged from hospital and unable to return home or to a former place of residence.
Northwest Territories	Valid NWT Health Care card. Live in an area where Home Care is available. Have assessed needs which can best be met by Home Care. Non-residents may be eligible for nursing services at a cost.	Persons 60 years of age and older are considered seniors.	Valid NWT Health Care card. Have assessed needs which can best be met by facility-based Long Term Care. (Non-residents may be admitted if they agree to pay service charges for the first 3 months exclusive of room and board.)

	Home Living	Congregate/supportive living	Continuing care centres
Nova Scotia	Resident of Nova Scotia with assessed unmet needs which can be safely and efficiently met at home.	58 years of age and older	For Residential Care Facilities/Homes for the Aged (Type 1 care): The person's medical condition must be relatively stable, they must be ambulatory or semi-ambulatory, they must require supervision and/or minimal assistance with the activities of daily living only, and they are normally continent. Those requiring lower levels of care will be approved for Residential Care Facilities. For Licensed Nursing Homes/ Homes for the Aged (Type 2 Care) : The person's medical condition must be relatively stable, they must not require medical attention more than once per week, and they must require intensive personal care under the supervision of a registered nurse. If they also exhibit marked confusion or disorientation, they will be placed in a psycho-geriatric section if one is available.
Ontario	1. Under Community Care Access Centres (CCAC's), visitng nursing, homemaking, and therapy services are available to people of any age according to the following criteria: • Ontario resident insured under the Ontario Health Insurance Act, • the person's condition is such that adequate treatment can be provided at home with the services available through the Community Care Access Centres (CCAC); • the person's needs cannot be met on an outpatient basis; • the residential environment is suitable for the provision of the required care: • the person's family or other appropriate persons are willing and able to participate in the program as required; and • the person is assessed to require one of the professional services provided by the CCAC and/or assistance with personal care and homemaking. Services may be provided on a short or long term basis and may include relief for caregivers of individuals with heavy care requirements. 2. Community Support Services do not have consistent eligibility criteria at the present time. Most services are provided by volunteers and client co-payments are permitted for goods (e.g. meals), expenses or services provided by paid workers. Provincial eligibility criteria are under development. 3. Attendant Outreach Services - These services have similar criteria to those of the CCAC's, but are generally provided for physically disabled adults under age 65.	In order to be eligible for supportive housing, a person must be at least 16 years of age, be infirm, physically disabled or cognitively impaired due to the aging process, illness or accident. This includes persons who are frail and elderly, people with physical disabilities, people with acquired brain injuries and people living with HIV/AIDS but does not include people with developmental disabilities. Supportive housing does not provide mental health services. In addition to the above criteria, most consumers will require services through a 24-hour period and be unable to have their services effectively delivered through the visiting services of the CCAC's in their community. Eligibility for personal support services and homemaking in supportive housing is based on the same criteria (functional determination of need) as those for the same services provided by the Community Care Access Centre.	The eligibility criteria for admission to a long term care (LTC) centre include: **Long Stay Program** - The applicant must 1) be over 18 years of age and 2) insured under the Health Insurance Act, plus 3) must meet at least one of the following • requires on-site nursing care on a 24 hour per day basis, • requires assistance each day with activities of daily living, • requires onsite supervision or on-site monitoring at frequent intervals throughout the day to ensure his or her safety or well-being; • at risk of being emotionally, financially, or physically harmed if the applicant lives in his or her residence; • the applicant is at risk of suffering harm due to environmental conditions which cannot be resolved if the person lives in his or her residence; and • the applicant may harm someone if the applicant lives in his or her residence. 4. Additionally, none of the publicly funded community-based services available to the applicant while the applicant lives in his or her residence and none of the other caregiving, support or companionship arrangements available to the applicant while the applican tlives in his or her residence are sufficient in any combination to meet the applicant's needs; or none of the above would be available in an area in which the applicant plans to move. 5. Finally, the applicant's needs can be met in a LTC centre. **Short stay program** - The same criteria apply for both respite and supportive care except for criteria #4 which does not apply.

	Home Living	Congregate/supportive living	Continuing care centres
Prince Edward Island	Eligible for PEI health care card. Non- residents may obtain home care provided the service is limited to three months and they assume liability for all costs including assessment, care coordination, personal care, support, or professional services. The individual must be assessed as medically stable, have needs which can be managed at home, unable to manage without service, and have a suitable and safe home environment. The individual must consent unless this has been waived by Adult Protection . As of 1996, clients have been categorized by 4 groupings- 1) Short Term Care- usually up to 30 days, 2) Intermediate Care, 60-90 days, 3) Continuing Care- ongoing, and 4) Special Needs or Specialized Services- to meet needs which exceed normal policies, exceed average costs and/or require a specialized resource base.	Assessed as able to manage safely in this environment, be independently ambulatory with or without mechanical aids, require care that is primarily supervision, psychosocial support and/or assistance with activities of daily living, and be stabilized or under clinical control if a medical condition exists.	Must be over 60 years of age. Canadian citizen or permanent resident. Resident of PEI for the last 12 months. Hold or eligible for PEI Health Care Card. Must be assessed at Level 4,5, or 6 due to health deterioration or increased risk related to functional, cognition and safety assessment. Medically stable. Able to be cared for in the nursing home.
Quebec			
Saskatchewan	Applicants must meet one of the following criteria: • hold a valid Saskatchewan Health Services Card; • be in the process of establishing permanent residence in the province and have applied for a Saskatchewan Health Services Card; or • be a resident of Manitoba or Alberta in a border area where contractual arrangements have been approved by Saskatchewan Health. Service may be provided to residents of other provinces who are visiting in Saskatchewan, provided that certain criteria are met. All applicants must undergo an assessment. Reassessments must occur within 30 days of admission and annually afterwards.	There are no provincially established eligibility criteria for the Personal Care Homes program as all homes are privately funded and operated. Subsidized seniors housing is provided through Saskatchewan Municipal Affairs, Culture, and Housing and tens to be geared toward low income seniors.	Individuals deemed eligible for residence in a special care home are admitted, based on assessed need when their needs can no longer be met in the community. District health boards have committees, sometimes called District Coordinating Committees (DCC) which provide a coordinated entry system for special care homes. These committees usually have representatives from hospitals, special care homes, home care programs, and frequently housing sectors. Staff from home care programs usually participate in the assessment of level of care and in prioritizing clients for admission to special care homes through the DCC's.
Yukon	Current Yukon health care insurance	1 year residency Assessed at Level 1	1 year residency requirement Assessed at levels 2-5

Note: The eligibility criteria for long-term care community services in Ontario are currently under review.

THE ROLE OF THE FAMILY

	Home Living	Congregate/supportive living	Continuing Care centres
Alberta	Home care supplements the care which a person's family is able to provide. Family members may not be paid for caring for their family members unless there are no qualified employees available (eg. sometimes in rural areas). This is usually only a temporary arrangement. Family members are considered parents, children, siblings, grandparents, grandchildren, married or common law relations, trustees, guardians, or other relatives living with the client.	N/A	N/A
British Columbia	One of the principles of the continuing care program is that it is "supportive in nature". There is an expectation that families, friends & neighbours will be involved with clients as the primary caregivers where possible.	Family involvement is encouraged with group home clients. (This usually applies to young adults.)	The role of the family diminishes when a client enters a care facility. It is hoped that family members are included in case conferences and planning. Many families have social work staff who often work with the whole family to problem solve. Families are not expected to give care.
Manitoba	Home care services support or augment the services available from the family, community and other resources. The home care program does not assume the role of primary caregiver. Services may be provided to relieve family caregivers to prevent deterioration of family support.	May include assisting with decision making and ADLs e.g. bills, rent, etc. Actively participate in extra curricular activities.	Address clients/residents social needs. Volunteers for facility activities are often drawn from family members. For residents who are unable to make their own decisions, family members are called upon to assist with decision making and to manage finances. Family members are expected to provide transportation for residents who have appointments outside of the facility.
New Brunswick	The Extra-Mural Hospital works to enable the client to be as independent as possible. They expect families to provide support and be taught whenever possible with the professional performing a monitoring function. For long term care, the informal support system is expected to assist in the care and support of the client to the extent that they are able and willing. This is assessed and built into the care plan. In-home and facility respite is available to support the caregivers.	The Extra-Mural Hospital would also teach caretakers in homes to provide care for clients.	Occasionally family members of clients in Nursing Homes may be involved in the rehab portion of their care and receive direction/supervision from the Extra-Mural staff.
Newfoundland	The Home Support Program, that is personal care, household management, and respite, has been designed to support, not replace, family; however there is no policy which targets the degree of family contribution to the client's care.	Nil.	Long term care facilities are staffed at appropriate levels to ensure the needs of residents are met. While some family members participate in feeding, toileting, and recreational activities, there is no requirement for them to augment the care provided by staff in these facilities.
Northwest Territories	Determined by each program depending on resources. Caregiver burden to be included in new assessment tool.	Determined by each program depending on resources. Caregiver burden to be included in new assessment tool.	None.
Nova Scotia	Home Care services hope to sustain the informal support system by supplementing the assistance available from the family, informal caregivers and other community resources.	Friends/family participate in decisions pertaining to the residents' continued occupancy and care requirements to remain in their home.	There are no policies or expectations regarding family support for residents in nursing homes.
Ontario	There are no policies outlining specific expectations for the level of support to be provided by family members or caregivers. However, since the in-home services and supports provided in Ontario are visitation services (i.e. services are not in the home 24 hours per day), the participation of family members and caregivers is a significant factor. The eligibility criteria for the in-home services [provided by CCAC's include a provision that family members or other caregivers are able and willing to provide care as required.	There are no policies related to expectations of family members living in supportive housing unless the individual service is, for some reason, ineligible for social assistance. In that case, the family would be responsible for the costs of room, board, clothing and other personal needs.	Long term care centres are expected to create an environment that encourages and enables families to actively participate in resident care and that supports and maintains family relationships (Note: this includes people who have had a close relationship with the resident). This may be accomplished through a variety of activities such as: flexible visiting hours, inclusion of family/ substitute decision makers in the assessment, planning, delivery, and evaluation of resident care programs and services, participation in a Family or Resident's Council at the request of the resident, participation in quality mangement program evaluations, and participation in an annual Family/Resident's Council meeting.
Prince Edward Island	Home care does not replace the community supports and resources, but rather identifies unmet needs and determines if additional Home Care	Community Care Facilities provide for independent residential living in a community based setting in a safe and reasonably supervised environment	Nursing Home residents are expected to contribute toward their cost of care, although may be subsidized under the Welfare Assistance Act.

	Home Living	Congregate/supportive living	Continuing Care centres
	services will, in fact, provide a safe appropriate setting.	for ambulatory and independent individuals who are experiencing some functional limitations and require limited amounts of personal care assistance.	Minimum contribution will be OAS, GIS, and other pension benefits as well as other sources of income as required. Income test is administered. Resident is responsible for the cost of items and services for personal use (i.e. hygiene, clothing, tobacco). Residents who are able to afford them are expected to cover the cost of special aide items (such as walkers). Spouse or dependents will not be jeopardized financially. Continued emotional and social support for family and community frequently make the difference for the resident adjusting to that high needs environment successfully. For routine transportation needs, additional or special personal needs, there is expected family or resident responsibility.
Quebec			
Saskatchewan	The home care program in Saskatchewan is meant to complement or supplement the support, care and services provided by family members to a client. There are no specific expectations regarding the level of support from family members.	Family members may act as "supporters" for residents in personal care homes. A supporter is defined as someone who acts as an advocate for the resident in their dealings, transactions and relationship with the licensee.	There are no policies delineating any level of support expected or required from family members of institutional long term care residents in Saskatchewan.
Yukon	None to date	None to date	None to date

INCENTIVES FOR FAMILY ASSISTANCE

	Yes	No	What is reimbursed	How is it reimbursed	Amount	% of public costs
Alberta	x		In certain exceptional cases, family members may be reimbursed for loss of income or other losses.			
British Columbia	x		Family assistance	Caregiver respite		
Manitoba		x				
New Brunswick		x				
Newfoundland		x			N/A	N/A
Northwest Territories		x				
Nova Scotia		x				
Ontario		x				
Prince Edward Island		x			N/A	
Quebec						
Saskatchewan		x			N/A	N/A
Yukon		x				

EXPECTED ROLE OF THE FAMILY IN FUNDING (i.e. user fees)

	Professional care	Support services	Housing	Factors considered in determining user fees
Alberta	N/A	N/A	N/A	Clients who do not receive income tested benefits (social allowance, guaranteed supplement, etc.) are expected to pay $5.00 per hour for home support services and $5.00 per meal to a monthly maximum of $300.00 based on a sliding fee scale.
British Columbia	No charge	Home support- The household net income (client/spouse) is used in the calculation of the user fee. Resident care- The rate is calculated 2 ways: client/spouse and client using net income. The lowest calculation is charged.	No expectation of the family. Group homes- Client pays a fee for room and board.	Net income, line 236 Tax paid MSP costs Base cost of living amount (for home support and residential care) Family unit size
Manitoba	Fees are not assessed for Home Care services.	Fees may be charged for associated services (e.g. Adult Day Care, Meals on Wheels).	There are per diem charges for clients in supportive housing projects and for residents of personal care homes. In Supportive Housing Projects, clients pay for full shelter and services costs. In Personal Care Homes a residential fee is determined based on income.	In Personal Care Homes the fee is based on reported income on the previous year's income tax return.
New Brunswick	No charge for professional services under the Extra-mural Hospital or LTC.	No charge for support services under the Extra-Mural Program. Under the LTC Program, support services are uninsured. Therefore the client is required to pay the full cost unless a subsidy is requested according to the Standard Family Contribution Policy. This applies to in-home, residential facilities and nursing homes.		The Standard Family Contribution Policy.
Newfoundland	Nil	Nil	Nil	N/A
Northwest Territories			There is no rent charged for seniors living in public housing. (If other family members live with them, rent is charged according to their income.) Long Term Care- Clients 19 years and over pay $712 per month for room and board. Income support is available if necessary.	When the rate of $712.00 was established for room and board in long term care, the government wanted to ensure that elders would have at least $200.00 per month of disposable income.
Nova Scotia	No charge except for Home Oxygen	Clients receiving home support, personal care and respite services from home support workers may be charged an hourly fee up to a monthly maximum based upon net income and family size. High density manors may offer on-site services to residents, including: foot clinics, congregate meals, health clinics, live-in building manager, caretaker and security.	Congregate/ supportive living residents are expected to pay monthly rent.	Nursing home care is not an insured service in Nova Scotia. Residents able to pay the full cost of care do so. Residents unable to pay are financially subsidized by the Department of Health. If a resident has a spouse remaining at home in the community, the couple's income and assets are divided. Other family members may make contributions on a voluntary basis.

	Professional care	Support services	Housing	Factors considered in determining user fees
Ontario	Community Care Access Centres (CCAC's) are 100% funded by the Ministry of Health. There are no user fees for professional services provided.	There are no fees charged for support services which are provided by CCAC's.	Residents in supportive housing receive medical care through the Ontario Health Insurance Plan. However, they are responsible for their own rent, food, clothing, and living expenses. In many cases, housing is subsidized by the provincial government and the cost of rent to the resident is 1/3 of their income. In other cases, housing is subsidized to market rental value and the subsidy is paid by the Ministry of Municipal Affairs and Housing. This responsibility is soon to be transferred to the municipalities. In continuing care centres, residents are charged for basic accommodation based on their ability to pay, with the province paying the difference. People in semi-private and private rooms must pay the full basic per diem plus a premium for preferred accommodation. Families are not expected to pay for resident's accommodation fees unless the resident is a sponsored immigrant. A long stay facility resident with a spouse in the community who does not have sufficient income to remain in the community may apply for approval to transfer up to $152.08 of their monthly income to the spouse in the community.	User fees supplement government funding for a number of community support services. Clients access these directly rather than going through CCAC's. These include: meals on wheels, meals to wheels, transportaion, home maintenance, respite, home help/homemaking, adult day service, and foot care. Residents of continuing care centres also pay for optional services such as cablevision, phones, and hairdressing which the facility makes available to the resident.
Prince Edward Island	N/A	Sliding scale means tested for in-home support worker - personal care, respite, environmental support based on personal monthly income.	Means tested (low income cut off) CMHC standards.	Monthly income Need for service based on standardized assessment Availability of alternate services. Individual ability to access alternate services - available transportation, mobility, distance, etc.
Quebec				
Saskatchewan	None. Clients do not pay for professional services.	None. Home Care clients pay for personal care and homemaker respite on an income tested basis.	None Personal care home residents pay for all services which they receive in their residence.	Income and expenses.
Yukon	None	None	None	Standardized per diem - no income testing

ROLE OF THE PUBLIC SECTOR - Professional Care

	Level of government					
	Local/municipal		Provincial/State		National	
	Health	Other	Health	Other	Health	Other
Alberta	Regional Health Authorities		Financing of regional health authorities.			
British Columbia	Health Authority		Allocates funding to health authorities and sets overall policy guidelines and standards for service provision.			

Manitoba	Regional Health Authorities		Responsible for policy and overall program standards.			
New Brunswick	Regional Hospital Corporations	Regional offices of FCSS and Mental Health	The Institutional Services Division sets overall policy, plans for and provides funding to eight hospital corpaortions which includes extramural hospitals.			
Newfoundland	Regional Health and Community Service Boards are responsible for home care service delivery.		The Department of Health and Community Services is responsible for policy direction, allocation fo resources to the region and program monitoring.			
Northwest Territories	Regional Health and Social Service Boards plan and deliver service.		The Department of Health and Social Services sets policy directions and transfers funds to 3 Community Services and Hospital Boards and 10 Regional Health Borads.			
Nova Scotia	Regional home care offices		Administration			
Ontario	Community Care Access Centres authorize professional services.		The province funds services.			
Prince Edward Island	Five Regional Health Boards are responsible for the financial management, strategic planning and operation of the program, as well as the delivery of home care services.		The Department of Health and Social Services is responsible for establishing the program's philosophy, mission, goals, objectives and policies, as well as program content and development, standards, evaluation, and staff education.			

Quebec	Eighteen regional health & social service boards asre responsible for the planning, budget allocations and coordination of health and social services, but not for the delivery of these services. 146 Local Community Services Centres (CLSC's) are responsible for service delivery.		The Ministry of Health and Social Services sets overall policy and plans for services.			
Saskatchewan			The Department of Health Community Care Branch provides overall direction by developing provincial objectives , policies, procedures, and standards in consultation with District Health Boards; provide consultative/advisory services; monitor outcomes; promote communication/liaison and allocates funding based on a population needs-based formula.		provide health/ transfer payments: funds some services on First Nations lands.	
Yukon				The Social Services branch of the Department of Health and Welfare administers the Yukon Home Care Program.		

ROLE OF THE PUBLIC SECTOR - Support Services

	Level of government					
	Local/municipal		Provincial/State		National	
	Health	Other	Health	Other	Health	Other
Alberta	Regional Health Authorities		Financing of regional health authorities.			
British Columbia	Health Authority		Allocates funding to health authorities and sets overall policy guidelines and standards for service provision.			
Manitoba	Regional Health Authorities		Responsible for policy and overall program standards.			
New Brunswick	Regional Hospital Corporations	Regional offices of FCSS and Mental Health	The Institutional Services Division sets overall policy, plans for and provides funding to eight hospital corpaortions which includes extramural hospitals.			
Newfoundland	Regional Health and Community Service Boards are responsible for home care service delivery.		The Department of Health and Community Services is responsible for policy direction, allocation fo resources to the region and program monitoring.			
Northwest Territories	Regional Health and Social Service Boards plan and deliver service.		The Department of Health and Social Services sets policy directions and transfers funds to 3 Community Services and Hospital Boards and 10 Regional Health Borads.			
Nova Scotia	Regional home care offices		Administration			
Ontario	Community Care Access Centres authorize professional services.		The province funds services.			

Prince Edward Island	Five Regional Health Boards are responsible for the financial management, strategic planning and operation of the program, as well as the delivery of home care services.		The Department of Health and Social Services is responsible for establishing the program's philosophy, mission, goals, objectives and policies, as well as program content and development, standards, evaluation, and staff education.			
Quebec	Eighteen regional health & social service boards asre responsible for the planning, budget allocations and coordination of health and social services, but not for the delivery of these services. 146 Local Community Services Centres (CLSC's) are responsible for service delivery.		The Ministry of Health and Social Services sets overall policy and plans for services.			
Saskatchewan			The Department of Health Community Care Branch provides overall direction by developing provincial objectives , policies, procedures, and standards in consultation with District Health Boards; provide consultative/advisory services; monitor outcomes; promote communication/liaison and allocates funding based on a population needs-based formula.		provide health/ transfer payments: funds some services on First Nations lands.	
Yukon				The Social Services branch of the Department of Health and Welfare administers the Yukon Home Care Program.		

ROLE OF THE PUBLIC SECTOR - Housing

	Level of government					
	Local/municipal		Provincial/State		National	
	Health	Other	Health	Other	Health	Other
Alberta	Regional Health Authorities	Alberta Municipal Affairs, private for profit and non-profit sectors				
British Columbia		Private, some non-profit				
Manitoba				Manitoba Housing		
New Brunswick						
Newfoundland						
Northwest Territories		Housing Authority				
Nova Scotia		12.5%	X	87.5%		
Ontario			x	Ministry of Municipal Affairs (Building Component)	Federal/Provincial Housing Program	
Prince Edward Island		Private sector sponsors for family housing				CMHC
Quebec						
Saskatchewan			X		provide health/ transfer payments: funds some services on First Nations lands	
Yukon				Social Services		

Nova Scotia - Housing is funded through property tax.

ROLE OF THE PRIVATE SECTOR

	Professional care	Support Services	Housing/capital	Financing
Alberta	N/A Nursing is available from some private agencies on a fee-for-service basis. Physical therapists are in private practice and have some funding from regional health authorities.	Private agencies provide many of the support services received by residents at home.	There is increasing involvement of the private sector in this area.	The private sector is involved in new construction.
British Columbia	None	Home support - Agencies may be private or non-profit to provide subsidized client home support services. They must have a service contract with the local health authority. (In 1997/98, 28% of home support hours were delivered by for-profit agencies.	In 1997/98, 143 nonprofit agency (11,146 beds) and 85 for profit agency (5,556 beds) .	The Ministry is currently supporting public/private (3P's) in the building of new facilities. Profit facilities are funded at a flat rate for property based on the funded occupancy levels. The April 1, 1998 rate is $8.44 per diem/per bed. An additional source of revenue is approved room differentials $3.00 to $9.00 per day.
Manitoba	There are private companies/agencies which offer home care services, but these organizations do not, for the most part, play a formal role in the delivery of continuing care services. There is a limited degree of contracted service provision in this area in the city of Winnipeg.		Supportive Housing projects may be public, non-profit, or private. Personal Care Homes are non-profit and proprietary.	
New Brunswick	Occasional contracting of private services for Physio or Respiratory on a short-term basis when there are recruitment difficulties.	Homemakers are contracted from the private sector.		
Newfoundland	Clients may contract privately.	Contracted Home Support Services by clients who have been assessed as needing both care and government funding and clients contracting privately.	Personal Care Home industry is a private for profit service to clients who require assisted supervised lining.	
Northwest Territories	None to date	None to date	None to date	None to date
Nova Scotia	Approximately 75% of Home Care nursing services are provided through a provincial contract with VON Nova Scotia. Home Oxygen services are provided through contracts with 5 oxygen vendors.	Home support services provided through the Home Care Program are provided by contracts with 24 home support agencies.	Twenty of the 70 nursing homes in Nova Scotia are owned by the private for-profit sector.	
Ontario	Through a Request for Proposal (RFP), Community Care Access Centres (CCAC's) purchase professional health care services (nursing, physiotherapy, occupational therapy, speech-language therapy, dietetic services) from for-profit and not-for-profit service providers. Private sector agencies providing these services are able to bid on contracts with the CCAC's.	The Long-Term Care Division through 5 regional offices funds Community Support Service Agencies to provide support services. For some of these services, an RFP process is used.	The private sector may enter into agreements that allow supportive housing arrangements to be located in private accommodation, but the actual rental agreement is with the individual client and they are responsible for their accommodation costs.	Historically Ontario has provided capital grants, on a cost share basis, to non-profit sponsors of long-term care facilities (including both homes for the aged and nursing homes). In contrast, private sector operators have had to arrange their own financing and manage costs through normally available operating funds when undertaking construction projects. Now the government is committed to one consistent funding approach for construction costs and one set of structural standards for all long-term care facility operators which will apply in the same manner regardless of the type of operator.
Quebec				

	Professional care	Support Services	Housing/capital	Financing
Prince Edward Island	Private practice fee-for-service is available across the Province for nursing, OT, physio, nutrition/dietetics, and audiology services.	There are private sector home support workers, resident care workers, and licensed nursing assistants or companion care services at a fee-for-service.	There are approximately 45,000 households in PEI, of which an estimated 85% are privately owned. The remaining estimated 6,000 households includes up to 1,700 seniors and social public housing units. From this extrapolation, we estimate approximately 4,300 rental units in private sector housing. These figures do not include approximately 1,000 nursing home beds, +/- 120 extended care beds, up to 700 community care residential beds, and approximately 480 acute care beds.	Insurance companies are providing LTC and Home Care insurance/investment programs where, based on the type of program purchased, up to $100.00/day could be claimed for health care services in-home or in a long term care facility. This has not become highly visible yet, but certainly provides a planning alternative for clients.
Saskatchewan	Seven home care programs in the north of the province are operated by the private non-profit sector. Some private firms provide professional services to individuals requesting them on a fee for service basis.	Private Personal Care Home operators provide support services to their residents. The private home care programs also provide support services to their clients. Additionally some private firms provide support services to individuals requesting them on a fee for service basis.	Six of the Special-care Homes are operated by the private for-profit sector; another 42 are operated by the private non-profit sector. There are also some private non-profit housing programs which provide accommodation to individuals and families who are charged market rents and who are subsidized depending on income levels.	Private institutions may provide loans to a small number of individuals who elect to secure privately based health care services, however this approach is rare.
Yukon	None to date	None to date	None to date	None to date

PLANNING GUIDELINES AND UTILIZATION PATTERNS

STAFFING - Home living

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
NURSING GROUP												
RN'S	x	Supervisor	x	x	x	x	x	x	x	x	x	x
RPN'S											x	
Clinical Specialists												
CAN/RNA/LPN/LNA	x		x				x	x	x		x	x
Nurse practitioner												
Nurse aide/healthcare aide/ resident care worker	x		x			x		x			x	x
Case Manager (nurse)	x	x	x		x	x		x	x	x	x	x
Attendant			x					x			x	
PHYSICIAN GROUP												
Community Medicine/ Public Health Physician	x										x	
Dermatologist												
Family Practitioner	x	x		x	x						x	x
Medical Geriatrician				x					x		x	
Physistrist				x								
Physical Medicine & Rehabilitation Specialist					x							x
Psychiatrist											x	
Resident												

Note: Physician services at home are provided on a fee for service basis in all Provinces.

PLANNING GUIDELINES AND UTILIZATION PATTERNS

STAFFING - Congregate/supportive living

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
NURSING GROUP												
RN'S				x		x			x			
RPN'S												
Clinical Specialists												
CAN/RNA/LPN/LNA									x			x
Nurse practitioner												
Nurse aide/healthcare aide/ resident care worker		In group homes	x	resident care workers				x	x		x	x
Case Manager (nurse)			x									
Attendant		x	x					x	x		x	x
PHYSICIAN GROUP												
Community Medicine/ Public Health Physician												
Dermatologist												
Family Practitioner	x	x		x					x		x	x
Medical Geriatrician				x					x			
Physistrist				x								
Physical Medicine & Rehabilitation Specialist												x
Psychiatrist												
Resident												

PLANNING GUIDELINES AND UTILIZATION PATTERNS

STAFFING - Continuing Care Centres

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
NURSING GROUP												
RN'S	x		x	x	x	x	x	x	x		x	x
RPN'S			x		x				x		x	
Clinical Specialists			RHA may hire as a resource to all facilities in the Region		x							
CAN/RNA/LPN/LNA	x		x	x	x	x	x	x	x		x	x
Nurse practitioner												
Nurse aide/healthcare aide/ resident care worker	x		x	x		x	x	x	x		x	x
Case Manager (nurse)						x			x		x	x
Attendant	x				personal care (limited)	x		x			x	x
PHYSICIAN GROUP												
Community Medicine/ Public Health Physician		x									x	
Dermatologist											x	
Family Practitioner	x	x	May receive a stipend to act as medical director	x	x	x	x	x			x	x
Medical Geriatrician				x		x			x		x	
Physistrist				x								
Physical Medicine & Rehabilitation Specialist					x	x					x	x
Psychiatrist											x	
Resident									x			

Note: In NWT& Newfoundland, the physician group in continuing care is used by the facilities, but not on the staff of the facilities.

Home Living

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Therapist Group												
Ambulance Attendant						x					x	
Audiologist												
Chiropractor											x	
Dietitian				x	x			x			x	
Nutritionist		x			x						x	
Naturopath												
Enterostomal Therapist					x			x			x	
Kinesiologist												
Massage Therapist												
Occupational Therapist	x	x	x	x	x	x		x	x	x	x	x
Osteopath											x	
Orthoptician/Prosthetician												
Osteopath												
Paratransport Attendant												
Physiotherapist	x	x	x	x	x	x		x	x	x	x	x
Psychotherapist											x	
Radiotherapist												
Recreational Therapist	x							x				
Rehabilitation Counsellor												
Respiratory Therapist		x	x	x		x	x	x		x	x	
Respiratory Technician											x	
Speech-Language Pathologist			x	x		x		x	x		x	x
Case Manager (Therapist)	x		x			x		x	x		x	x
Dietary Aide												
Therapist Assistant - Physiotherapy												
Therapist Assistant - Occupational Therapy												
Therapist Assistant- Speech Language Pathology		x										

PLANNING GUIDELINES AND UTILIZATION PATTERNS

Congregate/Supportive Living

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Therapist Group												
Ambulance Attendant						x						
Audiologist												
Chiropractor												
Dietitian				x								
Nutritionist											x	
Naturopath												
Enterostomal Therapist												
Kinesiologist												
Massage Therapist												
Occupational Therapist		x		x		x			x			
Osteopath												
Orthoptician/Prosthetician												
Osteopath												
Paratransport Attendant												
Physiotherapist		x		x		x			x		x	
Psychotherapist											x	
Radiotherapist												
Recreational Therapist												
Rehabilitation Counsellor												
Respiratory Therapist		x		x								
Respiratory Technician												
Speech-Language Pathologist				x								
Case Manager (Therapist)			x									
Dietary Aide	x											x
Therapist Assistant - Physiotherapy												
Therapist Assistant - Occupational Therapy												
Therapist Assistant- Speech Language Pathology		x										

PLANNING GUIDELINES AND UTILIZATION PATTERNS

Continuing Care Centres

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Therapist Group												
Ambulance Attendant						x					x	
Audiologist								x			x	
Chiropractor											x	
Dietitian	x		x		x		x	x	x		x	*
Nutritionist		x			x	x		x			x	
Naturopath												
Enterostomal Therapist		x									x	*
Kinesiologist												
Massage Therapist												
Occupational Therapist	x	x	Usually contracted for x hours / week	x	x	x	x	x	x		x	
Osteopath											x	
Orthoptician/Prosthetician												
Osteopath												
Paratransport Attendant												
Physiotherapist	x	x		x	x	x	x	x	x		x	*
Psychotherapist					on consult						x	
Radiotherapist												
Recreational Therapist	x		x		x	x	x	x	x		x	*
Rehabilitation Counsellor											x	
Respiratory Therapist		x		x	on consult				x		x	
Respiratory Technician									x		x	
Speech-Language Pathologist				x	on consult			x	x		x	
Case Manager (Therapist)						x					x	
Dietary Aide	x	x	x	x	x	x		x			x	*
Therapist Assistant - Physiotherapy	x	x	Some facilities may designate HCA as a rehab aide	x	x		x	x	x		x	*
Therapist Assistant - Occupational Therapy	x		Same as above	x	x			x	x		x	*
Therapist Assistant- Speech Language Pathology		*			on consult			x	x			

In PEI, Hospital resources are Regional Resources which may receive referrals from Home Care, Community Care facilities or Nursing Home residents/ clients. Although respiratory. speech, OT and Physio staff are located in hospitals, they may be sent to provide care in other locations.

PLANNING GUIDELINES AND UTILIZATION PATTERNS (continued)

Home Living

Service Provider	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Therapist Assistant/Activity Coordinator -Recreation Therapy												
Dentistry Group												
Dentist		x										
Dental Hygienist/ Assistant		x										
Denturist												
Technician Group												
X-ray Technician												
Laboratory Technician					x			x				
Others:												
Educator (formally trained teachers/ educators)												
Pharmacist		x									x	
Pharmacy Technician												
Psychologist												
Pastor/ Spiritual Counsellor											x	
Social Worker	x	x	x	x	x			x	x	x	x	x
Case Manager (Social Work)	x	x	x		x			x	x			
Alternative Healer												
Language Interpreter												
Home Support/ Home Care	x	x	x	x	x	x	x	x	private		x	
Worker					x							
Companion		x			x				private			
Homemaker	x		x	x		x		x	private		x	
Meals Provider	x	x	x	x		Meals on Wheels		x	volunteer		x	
Volunteer	x	x	x			x			Hospice		x	
Volunteer Manager	x							x				

Nova Scotia - In urban areas where there are a higher number of complex social/health issues, the community relations worker is a licensed social worker.
Nfld. - Home Support designation includes home managment (homemaker), respite (companion), and personal care.

PLANNING GUIDELINES AND UTILIZATION PATTERNS (continued)

Congregate/ Supportive Living

Service Provider	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Therapist Assistant/Activity Coordinator - Recreation Therapy												
Dentistry Group												
Dentist		x										
Dental Hygienist/ Assistant		x										
Denturist												
Technician Group												
X-ray Technician												
Laboratory Technician												
Others:												
Educator (formally trained teachers/ educators)												
Pharmacist		x									x	
Pharmacy Technician												
Psychologist												
Pastor/ Spiritual Counsellor												
Social Worker		x		x								
Case Manager (Social Work)												
Alternative Healer												
Language Interpreter												
Home Support/ Home Care Worker			x			x						
Companion		x	x									
Homemaker	x				x	x		x				
Meals Provider	x			x	x	Meals on Wheels						
Volunteer		x				x		x			x	
Volunteer Manager												

PLANNING GUIDELINES AND UTILIZATION PATTERNS (continued)

Continuing Care Centres

Service Provider	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Therapist Assistant/Activity Coordinator - Recreation Therapy	x	x	x		x		x		x			x
Dentistry Group												
Dentist		x			on consult				x		x	x
Dental Hygienist/ Assistant		x							x			
Denturist					on consult						x	
Technician Group												
X-ray Technician											x	
Laboratory Technician											x	
Others:												
Educator (formally trained teachers/ educators)			RN usually designated as inservice coordinator									
Pharmacist		x	contracted service				x				x	x
Pharmacy Technician												
Psychologist					on consult							
Pastor/ Spiritual Counsellor		x			x	x		x	x		x	x
Social Worker	x	x	x	x	x			x			x	x
Case Manager (Social Work)		x			on consult				x		x	x
Alternative Healer					on consult							
Language Interpreter					limited to Aboriginal groups	x						
Home Support/ Home Care Worker									private			
Companion		x							private			
Homemaker						x			private			
Meals Provider						x			volunteer			x
Volunteer	x	x			x	x	x	x	Hospice		x	x
Volunteer Manager	x	x										x

GUIDELINES FOR CONTINUING CARE CENTRE UTILIZATION PLANNING

	Type of Bed/ Service	Number per 1,000 population					
		Current (19 year)			Target year		
		<65	65-74	75+	<65	65-74	75+
Alberta							
British Columbia 1997/98							
	private hospital	9.56	282.45	3,029.10			
	family care home	3.65	74.73	949.04			
	extended care unit	70.59	947.76	10,586.75			
	personal/intermediate care home & other facility	43.98	1,322.44	20,460.35			
	group home for handicapped	19.64	16.55	10.21			
Manitoba	Personal care home beds (nursing homes) 1998			125			120 with development of alternative sources
New Brunswick	N/A						
Newfoundland							
Northwest Territories	None						
Nova Scotia	Nursing Homes and Homes for the Aged.			107			
Ontario	Long Term Care facility beds - no provincial or national guidelines. Beds are targeted on an equity approach which includes existing bed inventory, waiting lists, and the number of individuals age 75+.			91.6			93.7
Prince Edward Island	Nursing home	36	920 -all seniors	Mostly over 75			
Note: Presently there is a moratorium on new LTC beds.	Convalescent	16 beds-	all ages				
	Respite	10 beds- seniors					
	Palliative	8 beds- all ages					
Quebec							
Saskatchewan	Long-term Care (9,533 beds) 1997	11	126	133	N/A	N/A	N/A
Yukon	No guidelines						

GUIDELINES FOR CONTINUING CARE CENTRE UTILIZATION (continued)

	Inclusions/ exclusions	Target Group
Alberta		
British Columbia	None	Age 75+
Manitoba		The target group are those that are unable to be cost effectively cared for in the community. They typically are in the 80+ age group.
New Brunswick N/A		
Newfoundland		Persons 65 years and older. Persons less than 65 years who suffer from chronic, debilitating diseases such as MS.
Northwest Territories N/A		
Nova Scotia	Includes all age groups. Waiting lists were managed by municipalities in most areas of the province until April 1, 1998.	For nursing homes, the target is persons requiring Level 1 and Level 2 care.
Ontario		Majority are women over age 75. There has been a steadily growing number of LTC facility residents with more complex and difficult care requirements. A profile indicates that: more than 75% are in the mid to heavy care range, 42% suffer from dementias, 59% have some form of mental disorder, 59% are incontinent, and 70% require supports and assistance with activities of daily living.
Prince Edward Island		Seniors and adults with complex special needs - extended care. Highest need group targeted will be seniors with dementia, particularly those who require supervision and management related to aggressive or wandering behavioral problems. Respite care for caregiver support in conjunction with assessment and active restorative care where appropriate or possible.
Quebec		
Saskatchewan	The number of long-term care beds indicated above does not include self-pay, privately funded or Department of Veterans Affairs long-term care beds.	Clients who require continuous supervision and a high level of assistance and are usually partially or completely bedridden as the result of long-term illness or disabling condition. Heavy care (level 4 - i.e. requiring an average of 3 hours per day of hands-on care; some level 3 - requiring an average of 2 hours per day of hands-on care).
Yukon	Only criterion is level of care required.	Primary target group is frail seniors and those with dementia. Significant number of adults. Some children.

GUIDELINES FOR CONGREGATE/SUPPORTIVE LIVING UTILIZATION

	Type of Setting	Current (19 year)			Number per 1,000 population Target year		
		<65	65-74	75+	<65	65-74	75+
Alberta	144 lodges	7%	93%				
British Columbia	N/A						
Manitoba				10			10
New Brunswick	N/A						
Newfoundland							
Northwest Territories	Seniors lodges & Designated social housing units for seniors						
Nova Scotia	N/A						
Ontario	Supportive housing			15.2			
Prince Edward Island	N/A						
	Community Care Facility	200	N/A	N/A			
	Beds	N/A	500 beds seniors all ages				
Quebec							
Saskatchewan	Personal Care Homes (1,833 beds)	2	24	26	N/A	N/A	N/A
Yukon	N/A						

	Inclusions/ exclusions	Target Group
Alberta		
British Columbia	Private Sector operates congregate/supportive living.	No clear distinction in the absence of MOH funding for congregate/supportive living. In BC, group homes are part of the residential sector.
Manitoba		The current PCH planning guide is 120 per 1,000, 75+ age group. The previous ratio was 130 per 1000 at the 75+ age group.
New Brunswick	N/A	
Newfoundland	Private industry where market reaches its own level of service delivery. (?)	
Northwest Territories	N/A	
Nova Scotia		
Ontario		
Prince Edward Island	PEI These beds are private sector owned and operated and provincially licensed and monitored.	
Quebec		
Saskatchewan	N/A	
Yukon		N/A

GUIDELINES FOR PLANNING HOME CARE SERVICES

		Number of discrete clients per 1,000 population					
		Current (19 year)			Target year		
	Type of Service	<65	65-74	75+	<65	65-74	75+
Alberta							
British Columbia	April 1, 1997 - March 31, 1998 - Total number of unique clients = 130,789						
	Homemaker Service	1.74	23.79	167.66			
	Adult Day Care	.11	2.92	25.94			
	Nursing	5.04	31.06	98.21			
	Community PT/OT	1.72	15.41	70.64			
Manitoba	There are no fixed guidelines for home care planning.						
New Brunswick	Note: Unable to provide figures due to system utilization difficulties with Unit Information System (UIS)						
Newfoundland	Client assessed needs and per population. Currently developing a comprehensive referral management information system.						
Northwest Territories	None						
Nova Scotia	None						
Ontario - No guidelines. Demand and waiting lists are used as indicators of need.	Homemaking	3	37	147	N/A	N/A	N/A
	Nursing	8	53	129	"	"	"
	Occupational Therapy	3	13	43	"	"	"
	Physiotherapy	2	19	62	"	"	"
	Speech/Language Therapy	1	1	4	"	"	"
	Social Work	1	3	7	"	"	"
	Nutrition/Diet	0	4	8	"	"	"
Prince Edward Island	Acute care discharge (15%)	60%	40%				
	Intermediate Care (5%)	rehab up to 90 days- all ages					
	Continuing Care (75%)	Some	predominantly 65-95				
	Specialized	X	X	X			
Quebec							

GUIDELINES FOR PLANNING HOME CARE SERVICES (continued)

		Type of Service	Number of discrete clients per 1,000 population					
			Current (19 year)			Target year		
			<65	65-74	75+	<65	65-74	75+
Saskatchewan	1997-98	Includes palliative, acute, supportive care types; nursing, meals, home maintenance, and homemaking service types	5,506	4,444	17,998			
Yukon *	1998	Long term care	2.0	1.4	3.8			
		Acute care	1.8	.7	.7			
		Palliative care	.4	.4	.1			

* Yukon- A total of 44 clients received home care services outside Whitehorse; however they are not broken down by age.

GUIDELINES FOR PLANNING HOME CARE SERVICES (continued)

		Inclusions/ exclusions	Target Group
Alberta			
British Columbia		None	
Manitoba			
New Brunswick			
Newfoundland			
Northwest Territories	N/A		
Nova Scotia		The Home Care information system is under development. Detailed utilization data is not yet available.	
Ontario			
Prince Edward Island		PEI Home Care Support Program targets the elderly, adults with special needs as a support to individuals and families. It is not an acute care substitution or long term care substitution program.	
Quebec			
Saskatchewan		The above numbers do not include any privately provided home care services.	
Yukon			

CURRENT HOME CARE SETTINGS

	AB	BC	MAN	NB	NFLD	NWT	NS	ON	PEI	QUE	SASK	YUK
Home Setting			98%		Unavailable		30% home care 25% nursing		90%		95%	
Acute				x				40%				91%
Long term				x		x						73%
Palliative				x		x						100%
Congregate/supportive living setting			2%						10%		5%	
Acute				x								9%
Long term				x		x						27%
Palliative				x								
Differentiation-home living												
Target Group		No clear distinction between home and congregate/supportive living.		Adults age 19 and over	Levels 1 to 4	All ages		People of any age, including children with acute or chronic conditions or physical disabilities who can be treated or supported at home with the services available and the support to other caregivers.	Seniors or adults with special needs for care, services, support		Majority can manage independently with some support in their own home; usually self-directed; people usually have light to medium care needs	Own home or living arrangement
Funding				Maximum case plan of $2040. Per month	Combined private and government.	Provincial Health Care		$1,246.8 million	Professional service- no cost. Personal care- sliding scale.		91% publicly subsidized	Same
Other									Medications and supplies- client pays.			
Congregate/ supportive living												

Target		In BC, group homes are considered part of the residential (LTC) sector. Other congregate/supportive living is part of the private sector.	Beyond capacity of regular home care system and otherwise eligible for Personal Care Homes.	Adults age 19 and over	Levels 1 &2.Combined private and government.	Seniors over 60		Same as home living. The level of care that is required is the distinguishinf factor that determines which type of setting (i.e. home living or supportive living) is most appropriate. If the level of services required by a person exceeds the capability of CCAC's to deliver them cost effectively in a person's own home, the person would be eligible to move to a supportive housing setting.	Seniors or mentally challenged adults in residence. Some ongoing supervision.		Personal option; user pay; People usually have light to medium-heavy care needs.	Seniors subsidized apartments.*
Funding				Per diem rates for new clients effective April 1, 1999 $36.00 for special care homes, $105.00 for community residences	1			$99.2 million.	Subsidization based welfare assistance. Financial assessment.		100% user pay for PCH's; Subsidy in public housing.	Same
Other												

POPULATION AND AGING TRENDS - CURRENT

	0-4	5-9	10-19	20-24	25-44	45-64	65-74	75-84	85+
Alberta									
British Columbia	240,300	254,548	517,109	265,829	1,298,993	895,252	283,133	176,485	55,362
Manitoba 1997									
New Brunswick 1998 Stats Can	27,961	33,873	80,782	39,498	172,556	126,502	34,969	21,113	5,795
Newfoundland									
Northwest Territories									
Nova Scotia	53,959	62,414	127,006	65,011	292,458	212,435	65,492	43,857	14,043
Ontario	771,348	796,590	1,503,502	756,042	3,867,580	2,529,874	826,894	479,221	144,886
Prince Edward Island							9,304	6,307	2,238
Quebec									
Saskatchewan	68,325	78,781	161,706	73,088	299,314	201,888	75,430	53,644	19,757
Yukon									

Nova Scotia - not available. Refer to Stats Canada.
New Brunswick - unable to provide data due to system difficulties with Unit Information System (UIS)
Yukon - No data available.

POPULATION AND AGING TRENDS - PROJECTION 2016

	0-4	5-9	10-19	20-24	25-44	45-64	65-74	75-84	85+
Alberta									
British Columbia	284,693	281,939	575,364	332,540	1,491,519	1,495,152	497,157	239,480	108,523
Manitoba									
New Brunswick									
Newfoundland *									
Northwest Territories									
Nova Scotia	47,663	51,035	121,662	67,026	246,491	278,117	74,541	46,003	18,773
Ontario	794,523	802,222	1,704,080	939,077	3,910,163	4,056,954	1,312,141	696,595	317,871
Prince Edward Island									
Quebec									
Saskatchewan	67,753	71,272	136,300	66,667	266,924	283,681	91,032	47,391	23,935
Yukon *									

* Not available.

STRATEGIES/POLICIES/INNOVATIVE SERVICE MODELS TO ADDRESS THE AGING TREND

	Financing	Technology	Housing	Professional Care	Support Services	Provider reimbursement
Alberta		Wellnet is developing new information systems to provide timely, accurate information on health - finding the best ways to use technology to link and share health information while protecting privacy.		In June 1997 Alberta health released Achieving Accountability in Alberta's Health System which outlines an overall accountability framework for the health system.		
British Columbia		A health information system and an accountability framework are being developed in cooperation with the Heal.th Authorities.		A strategic plan for continuing care will be completed early in 1999.		
Manitoba		An automated screening, assessment and care planning tool (SACPAT) has been developed and planning is in process for its implementation across Manitoba during 1999-2000.	A Supportive Housing Initiative has been developed to provide additional community living opitons for people who otherwise would require Personal Care Home placement.			
New Brunswick	The Standard Family Contribution policy was implemented in 1997 and applied to Long Term Care services in New Brunswick. The intent is to establish a fair and equitable way of determining the level at which clients should contribute toward the cost of their services.	A new information database known as CSDS is being developed and will be phased in as the old system is being phased out. The LTC system is currently testing the use of a more generic assessment tool that involves one assessor rather than two. Based on certain indicators, referrals are made to a second LTC partner for further or specialized assessment. This results in more efficient use of human resources. The assessment tool is being tested in electronic format Assessors use a laptop computer, then upload the information to the CSDS database. Client information is only recorded once, and other assessors involved with the client have access to the information.	Long Term Care strategy introduced in 1993 includes a residential model and alternate family living arrangements.	An Evaluation Framework is being developed for the Extra-Mural Program.	A tendering process was introduced in 1997 for the purchase of home support services. The purpose is to ensure consistency in both cost and quality of the in-home service delivery provided by home support agencies across the province.	
Newfoundland		A Client and Referral Management Information System has been introduced.				

	Financing	Technology	Housing	Professional Care	Support Services	Provider reimbursement
Northwest Territories			Seniors Independent Housing Strategy is a federal and provincial initiative to provide housing to seniors at no cost to enable them to remain independent for as long as possible.			
Nova Scotia *			12 major capital improvement projects in the last 4 years.	Home Care Nova Scotia is involved in the collaborative effort between Nova Scotia and Prince Edward Island to undertake a demonstration project addressing palliative services in rural settings and is improving services to palliative clients of the program. Home Care Nova Scotia is working with the mental health sector to ensure existing home care services will be delivered to mental health clients in a safe and effective manner.	575 new FTE's funded in 70 facility budgets. Updated standards and curriculum for Home Support Worker training, developed collaboratively with providers and representative associations were implemented in 1999.	
Ontario	In April, 1998, the government announced a multi-year investment plan (eight years) that will move the province forward toward a coordinated, comprehensive health system that provides a continuum of care for people consistent with their needs. This is the largest-ever expansion of health services in Ontario; $1.2 billion will be invested to improve long-term care facility and long-term care community programs.		Over the eight years of the expansion plan, 20,000 new long-term care beds will be built by 2004/05 and $632.4 million will be invested in LTC facilities by 2005/06 to meet the increasing care requirements of residents and to meet the needs of the increasing number of elderly people. In addition to adding the equivalent of about 175 new facilities (20,000 beds), Ontarion is also rebuilding and renovating more than 100 older facilities so they will comply with new design standards that promote a better quality of life for all residents.	Over the 8 year expansion period, $595.8 million will also be invested in expanding and enhancing community services, such as in-home nursing, therapy, homemaking, supportive housing, attendant outreach and services for individuals with physical disabilities.	A new Personal Support Worker Program curriculum for the training of workers providing personal care and support to people living at home and in long-term care facilities, has been implemented and available through community colleges and private vocational training facilities since the fall of 1997.	

	Financing	Technology	Housing	Professional Care	Support Services	Provider reimbursement
Prince Edward Island	A system for service measurement has been developed. This is based on the hourly cost of service which includes salary and administrative costs, benefits, service associated supplies, training and travel. For example, the basic unit of service is based on one hour of support service $20.00. One hour of professional service = 2 units of service or $40.00.	The home care component od the Prince Edward Island System Evaluation Project is scheduled to be completed during 1998-99. It is evaluating care to those over 75 years of age, to look at services, integration and outcomes as well as validating the Continuing Care Screening Tool.		All five regions are participating in the development of a hospital-to-home protocal including strategy and funding to address the continuing demand for home care to support hospital discharge planning and follow-up care. A Provincial Geriatrician Position has been developed. This position is being shared with Veteran's Affairs Canada (20%) and is a resource to seniors' services, home care and continuing care across regional and provincial services and programs.		
Quebec		Release of a revised information system of client and service data (System d'information - clientele - CLSC) of software for the management of home care services is expected in the year 2000.		Integrated Palliative Care Pilot Project.	The development of "social economy" not-for-profit enterprises in domestic care support (6,000 employees projected) with 75 organizations operational at the end of 1998. They serve most non-prioritized home care clients, usually the elderly.	

	Financing	Technology	Housing	Professional Care	Support Services	Provider reimbursement
Saskatchewan	Annual funding for the provision of health supplies without charge to individuals receiving palliative care in their own homes or special care homes. Maintenance of a $250. cap on charges to seniors for road ambulance trips and a cap of $350 in patient charges for air-ambulance flight (seniors are high users of both road and air-ambulance services). Initiatives to reduce financial barriers for home care services have included elimination of charges for certain palliative supplies and drugs, IV drugs and supplies, and certain home care nursing supplies. Payments to physicians have been initiated for case conferences and telephone calls.	The Saskatchewan Health Information Network (SHIN) is being designed to provide an integrated health information system.	Saskatchewan Health is working with Saskatchewan Municipal Government Affairs, Culture and Housing to encourage collaboration between housing authorities and district health boards to develop creative social housing options.	Enhancement of client-centered home care services, enabling many seniors with health problems to remain in their homes. Between 1991/92 and 1998/99, home care funding has increased by 116%, while the range of home care services was expanded to include post-operative home care, post cardiac monitoring, pain management, rehabilitation services and home support for the frail elderly.	On March 24, 1998 the province announced the Assisted Living Initiative. This includes meals, laundry services, light and seasonal housekeeping, and a personal response system on a fee-for-service basis for tenants in senior social housing. Coordination of organized social and recreational activities such as transportation and tenant association activities is provided at no cost to the tenant.	
Yukon		Transportation		Home IV therapy is being piloted in Whitehorse (from Nov. '98 to Dec.' 99).		

Yukon has developed a document entitled "Growing Older in the Yukon", February 1999. It emphasizes improved quality of life for seniors and employs the following principles: respect, independence, equity, security, and partnership. Needs identified include: an emphasis on active living and wellness, the need for a wide range of housing options, more residential care beds, increased home care and respite, services for residents outside Whitehorse, and income security for adults who may no longer be employed but are not yet eligible for seniors benefits.

Nova Scotia - The Department of Housing is currently conducting a resident survey which addresses health, housing and social needs. The future position of the Department is dependent upon the results. Program/service initiatives will follow. The Department of Health is reviewing the concept of a single entry point assessment process and enhancement of services available to meet continuing care needs.

Newfoundland - A Seniors Advisory Council is to be established in 1999. Government has entered into major research activities into an evidence-based system for projecting long term care needs across the continuum from both community and facility based continuing care services. Program and Service evaluations are being completed to identify program appropriateness, efficiency and effectiveness. A major interdepartmental review is being conducted on all policies governing seniors services to ensure capability and effectiveness.

	Uniquenesses	Lessons		
		1	2	3
Alberta	The Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) Program was developed for seniors who may be otherwise eligible for admission to a continuing care centre or who are frequently admitted to hospital, but who choose to live in their own home. This Program offers a coordinated approach to health services and manages all the health requirements a senior may have.			
British Columbia	A single entry classification system which spans home support, residential care, and self-managed care.			
Manitoba	Manitoba employs a single-entry point approach to accessing services throughout the continuing care service continuum. The focus is on functional ability/disability rather than medical diagnosis.	Seniors require different service options to meet their individual needs.	Awareness of the services available and methods to access continues to be an issue.	
New Brunswick	The distinguishing feature of the Long Term Care system in New Brunswick is the partnership of the Departments of Health and Community Services in delivering long term care. The implementation of the Rehabilitation Services Plan (RSP) has resulted in the amalgamation of rehabilitation resource from Nursing Home Services, Family and Community Social Services, the Department of Education and the Extra-Mural Program into Community Rehabilitation Pools.			
Newfoundland	Non medical provincial model driven by the assessed needs of clients and operated by a professional single entry model framework under Regional Community Health Board.	Professional opinion is not necessarily compatible with seniors views.	The degree of interdepartmental coordination required for services delivery to seniors.	The need for clear lines of accountability in a regional service delivery model.
Northwest Territories	Lodges are available to seniors rent free. In NWT, persons over 60 are generally eligible for seniors programs and services. Majority of clients are aboriginal. Isolated, small communities. Home Care Coordinators serve as delegates for the Office of the Public Guardian. The home care coordinator's position has been designated as the public guardian representative in the regions.	Most people want to remain in their community - regardless of need.	Many family members do not feel responsible to care for elders/handicapped without being paid.	In many instances, people have given up their personal responsibility for health and well-being.
Nova Scotia	Enriched housing - In several areas throughout Nova Scotia, seniors manors are built adjacent to long term care facilities. Residents access service as needed and facility staff assess and monitor resident's needs on an ongoing basis. Nearby services enable residents to remain in their homes safely. A Provincial Risk Management Strategy is under developpment to address and minimize the risks involved with delivering care in the home. The funstions and tasks of providers have been revised, in collaboration with providers and associations, to foster appropriate assignment of functions.	Changes are resident driven; e.g. property management, service delivery level.	Special needs are carefully considered; i.e. mobility and health.	Communication needs to be clear, concise, and regular.
Ontario	In the spring of 1997, Ontarios's 76 Home Care and Placement Coordination Services programs were streamlined into 43 new Community Care Access Centres CCACs). These centres provide a single access point to a full range of long term care and other community services including: information on available services and programs, individual assessments, determination of clients' eligibility for services, planning individual care programs, and arranging for delivery of services. CCAC's are responsible for coordinating service delivery by purchasing services on behalf of their clients from for-profit and not-for-profit organizations such as the VON, Red Cross, or Paramed. The principal uniqueness in Ontario which resulted from the creation of the CCAC's is that all professional and support services are now contracted out through and RFP process which emphasizes highest quality as the first criterion and best price as the second. (In other words, the government has gotten out of direct provision of services.) This transition has occurred over a 3 ½ year period to allow providers to adjust. A side benefit which has resulted from the new RFP process is the development of innovative partnerships and collaborations; for example, among not-for-profit and for-profit agencies.	Care should be provided in the least interventional, least restrictive, least intrusive setting possible, taking into account the desires and circumstances of the patient.	There should be a single and consistent process for assessing need, determining eligibility, and organizing and securing long term care services regardless of the amount or type of care or the potential care setting.	The funding system for long term care should be unified and funding levels determined in relation to the needs of the resident, not the site in which care is provided. care should be funded at the same levels regardless of the type or ownership of facility care provider.

Prince Edward Island		Seniors are staunchly independent and want to remain so. They are hesitant to ask for services- Home Care, Respite, etc.	Female caregivers never ask early enough for assistance, and even then, do not ask for sufficient services.	Male caregivers are less than 15% of the population and are more apt to seek assistance more appropriately (i.e. sooner).
Quebec	SIPA (a system of integrated care for the frail elderly) is a community-based primary care system based on a patient-focused model designed to meet the needs of the frail elderly and to assure comprehensive care, integration of all available services and continuity of care by all professional and institutions involved. It is responsible for primary and secondary medical and social services, prevention, rehabilitation, medication, technical aids and long term care.			
Saskatchewan	On September 1, 1997 the Health Care Directives and Substitute Health Care Decision Makers Act was proclaimed. This Act upholds the right of individuals to provide for health care directives at the end of life, including designation of a proxy decision-maker in the event of personal incapacity.	It is best to have a community-based, client centered, and outcomes oriented approach to meeting senior" needs.	There is a preference for home based care with an increasing emphasis on non-institutional and supportive services care.	There has been a devolution of management and operational activities from the province to the health district, and a cautiously measured approach to innovative programs toward ensuring senior's care needs are being met.
Yukon				

BC - The Continuing Care Review is due to be released in April, 1999.
Ontario information was obtained from the Health Services Restructuring Commission report entitled: "Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies", A discussion Paper, July, 1997.

DESCRIPTION OF PROGRAMS AND SERVICES - International

	Home living	Congregate/supportive living	Continuing care centres
Denmark	1. Municipal Home Help includes personal care and practical assistance on a permanent basis. Most municipalities offer 24 hour domiciliary care service which integrates home nursing and home help services. 2. Preventive visits are made twice per year to persons over 75 years of age. 3. Day centres offer care and rehabilitation ser vices.	Same services as home living, as seniors living accommodations are independent housing units; i.e. the residents are tenants.	Since 1988, Denmark has been creating housing units with associated service areas and a permanent staff in which the residents are considered tenants and not residents as in an institution. There are still some nursing homes in existence; however they are gradually being phased out.
The Netherlands	Home Care. **First Line Aid** (the entrance to health care such as family doctors, and paramedical professions). Adjustments for the disabled in their living surroundings (readjustments in their homes and appliances). Daycare centers and day treatment programs. Additional appliances and services such as meals on wheels.	Service assistance apartments (where no 24 hour nursing assistance is provided)	CCC (nursing homes) including all senior living accommodations where 24-hour nursing assistance is provided.

ELIGIBILITY CRITERIA

	Home Living	Congregate/supportive living	Continuing care centres
Denmark	People are assessed according to need. Services levels may vary among municipalities.	Housing units are available to seniors and to persons with disabilities who require specialized housing.	Based on assessed need.
The Netherlands	**First line Aid** - free and open admission for family doctors. For other health professionals, a physician's referral is required. **Home Care**- an independent commission determines your need for care based on objective criteria which are: home situation, (volume, square meters, stairs), environment (attainableness of stores and other provisions like a library), social network, level of care which is already given.	Same as for home living.	The same independent commission mentioned under home living determines what care is needed: home care, a day care centre, move to a nursing home, or another CCC.

THE ROLE OF THE FAMILY

	Home Living	Congregate/supportive living	Continuing Care centres
Denmark	Spouse and children living with the person are expected to assist according to what can reasonably be expected, and the municipality is permitted to assess the persons need on this basis.	None.	None.
The Netherlands	The basic idea is that there is no obligation to support the family. Nevertheless before professional care or support services start delivering services they make an inventory of the level of family support. They also make arrangements with the family, relatives, or friends about who does what, especially in the home living stream. The normal care will be given by the social network (such as care for the elderly with flu). For all extra care one can depend on professional care. The line between normal care and extra care is not very clear.		In the 24 hour stream there are almost no expectations of the family to provide care; however laundry, support with shopping and the buying of new clothes is mostly done by the family.

INCENTIVES FOR FAMILY ASSISTANCE

	Yes	No	What is reimbursed	How is it reimbursed	Amount	% of public costs
Denmark	x		Caring for a dying person.	The municipality pays the relative.	Maximum is 200.000 Dk.	
The Netherlands		x				

EXPECTED ROLE OF THE FAMILY IN FUNDING (i.e. user fees)

	Professional care	Support services	Housing	Factors considered in determining user fees
Denmark	None	None	None	N/A
The Netherlands	N/A	N/A	N/A	N/A

ROLE OF THE PUBLIC SECTOR - Professional care

	Level of government					
	Local/municipal		Provincial/State		National	
	Health	Other	Health	Other	Health	Other
Denmark		For seniors		For disabled		
The Netherlands					x	

In the Netherlands, The AWBZ (Exceptional Medical Expenses Act) provides for a National insurance scheme under which everyone is insured regardless of income or profession and regardless of whether or not contributions have been paid. The AWBZ covers serious medical risks such as long term illness or serious disability, the cost of which cannot be borne by the patient and for which it is difficult or impossible to obtain insurance coverage. This includes extended hospital stay, home care, nursing homes, out-patient and institutionalized mental health care. In 1992 this represented 15 million people.
Fl 120.000.000 (Dutch gilders). This is for the total budget. No distinction is made on what sort of care/support budget holders use the money for. This represents less than 1% of public costs for elderly care (total paid is F 15,5 billion Dutch gilders).
The system is funded through a combination of property and personal taxes.

The Health Insurance Act (ZFW) covers non-exceptional medical risks such as general practitioner services, dental care, specialized medical care, maternity services, hospital services and transportation. It is compulsory for all employees and recipients of social welfare payments with an annual income below a yearly adjusted specific level. In 1992, approximately 2/3 of the population was covered under this Act.

Approximately 5.6 million persons in Holland at one third of the population are privately insured for non-medical risks. This group contains the self-employed as well as those over a certain income level. Private insurance is voluntary and individuals may carry some of the risk themselves. The statutory health insurance schemes for public servants are also regarded as private health insurance.

The Dutch Health and Social Services system is currently undergoing reform. Eventually residents will have compulsory basic health insurance which will cover approximately 90% of all current medical and social services, namely; general practitioner services, prescribed drugs, medical/ nursing aids and appliances, paramedical services, preventive care, obstetric and maternity services, nursing, treatment and care for the elderly and the mentally and physically handicapped, rehabilitation, medical and surgical treatment and associated short-term hospital stay, psychosocial care, dental care, and transportation services. Apart from the mandatory basic coverage, individuals may opt for voluntary supplementary coverage for provisions such as cosmetic surgery.

Premiums for basic coverage will be divided into 2 parts: the consumer will pay approximately 80% of the premiums based on taxable income and they will also pay a flat rate premium to their insurance company (care is delivered through insurance companies). It is intended that this will encourage competition among insurers to become more efficient. The insured will have free choice of insurers, but insurers will be obliged to accept all applicants regardless of risk and/or health status. They will also not be allowed to differentiate health premiums to clients according to risks.

ROLE OF THE PUBLIC SECTOR - Support Services

	Level of government					
	Local/municipal		Provincial/State		National	
	Health	Other	Health	Other	Health	Other
Denmark		x				
The Netherlands					x	

In the Netherlands people can get a Personal Care Budget (in Dutch called a PGB). This is a substitute for AWBZ care-in-kind. Patients receive a budget from the insurance company with which they can buy the care they want for themselves. This is the only method by which it possible to pay non-professional workers.

ROLE OF THE PUBLIC SECTOR - Housing

	Level of Government					
	Local/ municipal		Provincial/state		National	
	Health	Other	Health	Other	Health	Other
Denmark		x				
The Netherlands						x

ROLE OF THE PRIVATE SECTOR

	Professional care	Support Services	Housing/capital	Financing
Denmark	The municipality decides who supplies services; generally it is the municipalities themselves. The private sector has a marginal but growing role in supplying services.	Yes.	Yes	None
The Netherlands	All 24 hour professional care is provided by foundations. These foundations are responsible for providing all services needed. Home Care foundations deliver professional nursing care. Other professional care such as physical therapy isalso available for elderly people with a doctors referral.	Home Care foundations deliver housekeeping to people who live at home or similar living environments. Some of them also deliver special services like small technical assistance or gardening. When this is not available people who live at home must hire a gardener or technician themselves. Meals are delivered by the Meals on Wheels foundation.	There are also foundations which provide houses and living surroundings for elderly people.	

PLANNING GUIDELINES AND UTILIZATION PATTERNS

STAFFING - HOME LIVING

	Denmark			The Netherlands
NURSING GROUP				
RN'S	x			x
RPN'S				
Clinical Specialists				
CAN/RNA/LPN/LNA				x
Nurse practitioner				x
Nurse aide/healthcare aide/ resident care worker	x			x
Case Manager (nurse)	x			
Attendant				
PHYSICIAN GROUP				
Community Medicine/ Public Health Physician				
Dermatologist	x			
Family Practitioner	x			x
Medical Geriatrician	x			
Physistrist	x			
Physical Medicine & Rehabilitation Specialist	x			
Psychiatrist	x			
Resident				

PLANNING GUIDELINES AND UTILIZATION PATTERNS

STAFFING - Congregate/Supportive Living

	Denmark			The Netherlands
NURSING GROUP				
RN'S	x			
RPN'S				
Clinical Specialists				
CAN/RNA/LPN/LNA				
Nurse practitioner				
Nurse aide/healthcare aide/ resident care worker	x			
Case Manager (nurse)	x			
Attendant				
PHYSICIAN GROUP				
Community Medicine/ Public Health Physician				
Dermatologist	x			
Family Practitioner	x			
Medical Geriatrician	x			
Physistrist	x			
Physical Medicine & Rehabilitation Specialist	x			
Psychiatrist	x			
Resident				

PLANNING GUIDELINES AND UTILIZATION PATTERNS

STAFFING - Continuing Care Centres

	Denmark			The Netherlands
NURSING GROUP				
RN'S	x			x
RPN'S				x
Clinical Specialists				x
CAN/RNA/LPN/LNA				x
Nurse practitioner				x
Nurse aide/healthcare aide/ resident care worker	x			x
Case Manager (nurse)	x			
Attendant				
PHYSICIAN GROUP				
Community Medicine/ Public Health Physician				
Dermatologist	x			x
Family Practitioner	x			
Medical Geriatrician	x			x
Physistrist	x			x
Physical Medicine & Rehabilitation Specialist	x			
Psychiatrist	x			x
Resident				

	Denmark			The Netherlands
THERAPIST GROUP				
Ambulance Attendant	x			x
Audiologist	x			x
Chiropractor				x
Dietitian				x
Nutritionist				x
Naturopath				x
Enterostomal Therapist				
Kinesiologist				
Massage Therapist	x			x
Occupational Therapist				x
Optometrist				
Orthoptician/Prosthetician	x			
Osteopath				x
Paratransport Attendant				x
Physiotherapist	x			x
Psychotherapist				
Radiotherapist	x			
Recreational Therapist				
Rehabilitation Counsellor				
Respiratory Therapist	x			
Respiratory Technician	x			
Speech-Language Pathologist	x			x
Case Manager (Therapist)				
Dietary Aide				
Therapist Assistant - Physiotherapy				
Therapist Assistant - Occupational Therapy				
Therapist Assistant- Speech Language Pathology				

PLANNING GUIDELINES AND UTILIZATION PATTERNS

Congregate/Supportive Living

	Denmark			The Netherlands
THERAPIST GROUP				
Ambulance Attendant	x			
Audiologist	x			
Chiropractor				
Dietitian				
Nutritionist				
Naturopath				
Enterostomal Therapist				
Kinesiologist				
Massage Therapist	x			
Occupational Therapist				
Optometrist				
Orthoptician/Prosthetician	x			
Osteopath				
Paratransport Attendant				
Physiotherapist	x			
Psychotherapist				
Radiotherapist	x			
Recreational Therapist				
Respiratory Technician				
Rehabilitation Counsellor	x			
Respiratory Therapist	x			
Speech-Language Pathologist	x			
Case Manager (Therapist)				
Dietary Aide				
Therapist Assistant - Physiotherapy				
Therapist Assistant - Occupational Therapy				
Therapist Assistant- Speech Language Pathology				

	Denmark			The Netherlands
THERAPIST GROUP				
Ambulance Attendant	x			
Audiologist	x			
Chiropractor				
Dietitian				x
Nutritionist				x
Naturopath				
Enterostomal Therapist				
Kinesiologist				
Massage Therapist	x			x
Occupational Therapist				x
Optometrist				
Orthoptician/Prosthetician	x			
Osteopath				
Paratransport Attendant				
Physiotherapist	x			x
Psychotherapist				
Radiotherapist	x			
Recreational Therapist				x
Rehabilitation Counsellor				
Respiratory Therapist	x			
Respiratory Technician	x			
Speech-Language Pathologist	x			x
Case Manager (Therapist)				
Dietary Aide				
Therapist Assistant - Physiotherapy				
Therapist Assistant - Occupational Therapy				
Therapist Assistant- Speech Language Pathology				

PLANNING GUIDELINES AND UTILIZATION PATTERNS (continued)

Home Living

SERVICE PROVIDER	Denmark			The Netherlands
Therapist Assistant/Activity Coordinator - Recreation Therapy				x
Dentistry Group				x
Dentist	x			x
Dental Hygienist/ Assistant	x			x
Denturist	x			
Technician Group				
X-ray Technician	x			
Laboratory Technician	x			
Others:				
Educator (formally trained teachers/ educators)				
Pharmacist				x
Pharmacy Technician				
Psychologist				
Pastor/ Spiritual Counsellor	x			
Social Worker				x
Case Manager (Social Work)				
Alternative Healer				x
Language Interpreter				x
Home Support/ Home Care				x
Worker				x
Companion				
Homemaker				
Meals Provider				x
Volunteer				x
Volunteer Manager				x

PLANNING GUIDELINES AND UTILIZATION PATTERNS (continued)

Congregate/ Supportive Living

SERVICE PROVIDER	Denmark				The Netherlands
Therapist Assistant/Activity Coordinator - Recreation Therapy					
Dentistry Group					
Dentist	x				
Dental Hygienist/ Assistant	x				
Denturist	x				
Technician Group					
X-ray Technician	x				
Laboratory Technician	x				
Others:					
Educator (formally trained teachers/ educators)					
Pharmacist					
Pharmacy Technician					
Psychologist					
Pastor/ Spiritual Counsellor	x				
Social Worker					
Case Manager (Social Work)					
Alternative Healer					
Language Interpreter					
Home Support/ Home Care					
Worker					
Companion					
Homemaker					
Meals Provider					
Volunteer					
Volunteer Manager					

PLANNING GUIDELINES AND UTILIZATION PATTERNS (continued)

Continuing Care Centres

Service Provider	Denmark				The Netherlands
Therapist Assistant/Activity Coordinator - Recreation Therapy					
Dentistry Group					
Dentist	x				
Dental Hygienist/ Assistant	x				
Denturist	x				
Technician Group					
X-ray Technician	x				
Laboratory Technician	x				
Others:					
Educator (formally trained teachers/ educators)					
Pharmacist					x
Pharmacy Technician					
Psychologist					
Pastor/ Spiritual Counsellor	x				x
Social Worker					x
Case Manager (Social Work)					
Alternative Healer					
Language Interpreter					
Home Support/ Home Care					
Worker					
Companion					
Homemaker					
Meals Provider					
Volunteer					
Volunteer Manager					

GUIDELINES FOR CONTINUING CARE CENTRE UTILIZATION PLANNING

	Type of Bed/ Service	Total Population	Current (19 year)			Number per 1,000 population Target year		
			<65	65-74	75+	<65	65-74	75+
Denmark								
The Netherlands								
	somatic care (nursing home)	25,302 (16,0/1,000)						
	psychogeriatric (nursing home)	27,272 (17,7/1,000)						
	service homes with 24 hour assistance	114,500 (7,4 / 1,000)						
	psychiatric chronic care	13,545 (2,0/1,000)						
	mentally handicapped care	approx. 30,000 (2,0/ 1,000)						

GUIDELINES FOR CONTINUING CARE CENTRE UTILIZATION (continued)

	Inclusions/ exclusions	Target Group
Denmark	No guidelines; decided by municipalities.	People who cannot be helped at home.
The Netherlands	There is no distinction made by age per group. We only register the total number of spaces provided by category. For psychiatric care and mentally handicapped care we only know the total numbers which include all ages, not only the elderly. Therefore the number of beds in psychiatric chronic care are not only for elderly people (65+). The number of beds for the mentally handicapped care is estimated, based on numbers for the total amount of beds.	

GUIDELINES FOR CONGREGATE/SUPPORTIVE LIVING UTILIZATION

	Type of Setting	Current (19 year)			Number per 1,000 population Target year		
		<65	65-74	75+	<65	65-74	75+
Denmark							
The Netherlands							

	Inclusions/ exclusions	Target Group
Denmark	None - the municipality decides.	
The Netherlands		

GUIDELINES FOR PLANNING HOME CARE SERVICES

	Type of Service	Total numbers	Current (19 year)			Number of discrete clients per 1,000 population Target year		
			<65	65-74	75+	<65	65-74	75+
Denmark								
The Netherlands 1997	housekeeping	11.195.892						

	family care	38288.542						
	nurse practitioner	not registered separately in 1997						
	registered nurse	3.090.699						

GUIDELINES FOR PLANNING HOME CARE SERVICES (continued)

	Inclusions/ exclusions	Target Group
Denmark	None - the municipality decides.	
The Netherlands		

The Netherlands - For home living we do not register by number of spaces, but by number of hours care/help offered to people by the insurance company. They make arrangements with the home care foundations about how much budget/hours care they can give in a year. Recently more help is provided than planned because of increased demand for care.

CURRENT HOME CARE SETTINGS

	Denmark			The Netherlands
Home Setting	90%			
Acute				
Long term				
Palliative				
Congregate/supportive living setting	10%			
Acute				
Long term				
Palliative				
Differentiation- home living				own house or flat, with absolutely no service in the house
Target Group				
Funding				
Other				
Congregate/ supportive living				apartment building or service flat, with a hall-porter and organized gardening. Also there is usually a community room.
Target	Assessed need for housing for the elderly.			
Funding	State, municipality, & tenants.			
Other				

The Netherlands - There are no group homes or lodges in which home care provides services.

POPULATION AND AGING TRENDS - CURRENT

	0-4	5-9	10-19	20-24	25-44	45-64	65-74	75-84	85+
Denmark	346.292	325.317	578.036	357.920	1570986	1324841	419217	278.635	93.616
The Netherlands									

POPULATION AND AGING TRENDS - PROJECTION 2016

	0-4	5-9	10-19	20-24	25-44	45-64	65-74	75-84	85+
Denmark	297.172	313.435	692.553	365.129	1353313	1494065	598613	279515	99445
The Netherlands									

STRATEGIES/POLICIES/INNOVATIVE SERVICE MODELS TO ADDRESS THE AGING TREND

	Financing	Technology	Housing	Professional Care	Support Services	Provider reimbursement
Denmark						
The Netherlands						

Denmark - The government is providing specific descriptions of eligibility criteria and services provided in order to adjust public perceptions to realities.

The Netherlands - In general the policy of the government is substitution of intramural (residential) care to extramural (non-residential) care. This follows the wish of elderly people to live in their own house and environment as long as physically and mentally possible. As long as people are no danger to themselves and their surroundings, they can receive all care and services needed at their home.

	Uniquenesses	Lessons		
		1	2	3
Denmark	Most services are supplied by the public sector. A large proportion of elderly people receive care service (home help).	As information about services is improved, people are more satisfied.		
The Netherlands	Substitution of intramural (residential) care for extramural (nonresidential) care is a key policy of the Dutch Government which supports the wishes of elderly to stay independent as long as possible. It is also important in addressing the aging trend in Holland. Government is aware that at some point more substitution from intramural care to extramural care is no longer justified and institutional care becomes necessary. **Decrease of intramural bed capacity.** There is a growth of number of beds foreseen in the CCC's with complex care. On the other hand there is a descend (decrease) in the number of beds foreseen in the 24 hour homes with basic care. In general the amount of intramural beds is decreasing; i.e. the number of beds per older person. Therefore the weight of care (case mix, comorbidity) in the intramural sector will increase. Research is being undertaken to measure what this means for number of careworkers per bed. Another trend is that CCC's can use their budget to deliver care in the extramural situation (for example daycare, incidental night care for elderly who still live at home) **Privacy** -In CCC's, rooms which used to house 5-6 persons are being transformed to care for 1-2 persons to increase privacy. **Extra care in CCC's with basic care** - In CCC's with basic care, units are being developed to be able to provide complex care. **Care Innovation Fund** - The Care Innovation Fund makes it possible to fund innovative care outside of regular budgets. These are evaluated and may become part of the regular budgets. **Separation of housing, caring, and services**- In CCC's for complex care integrated housing, professional care and services are offered and financed by collective funds. Also in CCC's for basic care, integrated housing, caring, and services are offered and financed. It has been questioned whether the living and service portions in CCC's must be funded from collective funds. Individuals can be held responsible for organizing and financing residential and service costs by themselves and this trend is likely to become the norm in the future. **Maximization of Home Care**- Home care is in principle maximized at 3 hours per day. For special groups and in special situations, more intensive care can be funded. **Efficiency of Care** - A large push towards more efficiency in home care through benchmarking and output financing is being undertaken by the Dutch government. **Entrance to Care (Indication)**- Indication for home care traditionally was executed by home care providers themselves. Since 1998, the indication for home care has been managed by an independent bureau. **Information about usage, provision, waiting list, etc. -** A lot of the current information regarding usage, provision, waiting lists, etc. is not valid or reliable. The government is trying to correct this. **Distinction between intramural (residential) and extramural (non-residential) care-** Currently there are strict boundaries between intramural and extramural care because they are financed differently; however the government intends to open these boundaries in the future in order to facilitate substitution of care (seamless system).	Substitution from intramural (residential) to extramural) care is cheaper and addresses the desire of the elderly to live in their own homes as long as possible.	Counter-vailing power of insurance companies. The insurance companies receive a budget from the government to make arrangements with health care providers about how much care they deliver for the budget. This is an attempt to control the growing costs of health care and also to make sure that all basic health is provided.	The need to encourage efficiency- Instead of giving more money to CCC's and other health care deliverers, the government has begun to give money to institutes that have shown that they spend their money wisely. Institutes that do not operate efficiently have their budgets cut.

Appendix F

Alberta Municipal Affairs Supportive Housing Survey Respondents

Project Name	Address	City	Postal Code	Year of Operation	Project Type *
Bethany Care Airdrie	1736-1 Avenue	Airdrie		1987	2
Fletcher Village	305-1 Avenue	Airdrie		1999	1
Orchard View		Brooks		1999	1
Agape Manor Hospice	1302 - 8th Avenue NW	Calgary	T2N 1B8	1992	2
Bethany Care Centre - Calgary	916-18 A Street NW	Calgary	T2N 1C6	0	2
Canyon Meadows Retirement Residence	12 Deerview Terrace SE	Calgary	T2J 7E6	1994	1
Dana Village	1818 Simcoe Blvd SW	Calgary	T3H 3L9	1996	2
Jackson House	3021 - 15 Avenue SW	Calgary	T3C 3W7	1996	2
Pathways Palisades	340 - 14 Avenue SW	Calgary	T2R 1H4	1996	1
Royal Park	4315 Richardson Road SW	Calgary	T3E 7J7	1998	7
Scenic Acres	8720 Scurfield NW	Calgary		1999	1
Sundance on the Green	3 Sunmills Green SE	Calgary	T2X 3N9	1999	2
The Edgemont	80 Edenwold Dr NW	Calgary	T3A 5R9	1997	1
The Lodge at Valley Ridge	11320 Valley Ridge Blvd NW	Calgary		1999	1
The Manor Village at Huntington Hills	6700 Hunterview Drive NW	Calgary	T2K 6K4	1999	1
The Manor Village at Signature Park	1858 - Sirocco Drive NW	Calgary	T3H 3P7	1997	1
The Pavilions of Huntington Hills	6700 Hunterview Drive NW	Calgary	T2K 6K4	1999	1
The Renoir	9229 - 16th Street SW	Calgary	T2V 5H3	1988	1
The Westview	5033 - 45 Street SW	Calgary	T3E 7H1	1996	2
Trinity Lodge	1111 Glenmore Trail SW	Calgary	T2V 4C9	1975	1
Wentworth Manor	5717 - 14 Avenue SW	Calgary	T3H 3M2	1998	2
Westbourne Place	877 - 64 Avenue NW	Calgary	T2K 5J4	1974	2
Willian House	3105 - 15 Avenue SW	Calgary	T3C 3W7	1996	2
Camrose Crown Care	4623-65 Street	Camrose	T4V 4R3	1999	1
Madyson Manor	5511-50 Avenue	Camrose	T9A 0T4	1998	1
Canterbury Court	8403 - 142 Street	Edmonton	T5R 4L3	1972	1
Canterbury Manor	8311 - 142 Street	Edmonton	T5R 5Y5	1992	2
Churchill Manor	5815-34 Avenue	Edmonton	T6L 7B8	1998	1
Claire Estates	10305-100 Avenue	Edmonton		1999	1
Devonshire	9904-142 Street	Edmonton	T5N 2N5	1998	1
Eden Place	10610-87 Street	Edmonton	T5H 1N8	1998	1
Edmonton Chinese SeniorsLodge	9525 - 102 Avenue	Edmonton	T5H 0G2	1997	2
Emmanuel Home	13425 - 57 Street	Edmonton	T5A 2G1	1973	2
Garneau Hall	10923 - 82 Avenue	Edmonton	T6G 2N9	1978	2
Garneau United Place	11148-84 Avenue	Edmonton	T6G 0V8	2000	2
Kings Street Cottage	(Summerlea)	Edmonton		1999	1
Lifestyle Options	4069-106 Street	Edmonton	T6J 2S3	1999	1
Lions Village Castledowns	159 A Avenue - Castledowns Rd. (113 St.)	Edmonton		1998	2
Mayfair Plaza	10815 Jasper Avenue	Edmonton	T5J 2B1	1996	1

Project Name	Address	City	Postal Code	Year of Operation	Project Type *
Meadowcroft Seniors' Residence	11445 - 135 Street	Edmonton	T5M 3M6	1972	2
Millwoods Manor	6640 - 28 Avenue	Edmonton	T6K 3X8	1978	2
Riverbend Retirement Residence	103 Rabbit Hill Road	Edmonton		1999	1
Rosedale Manor	10053 - 111 Street	Edmonton	T5K 2B1	1999	1
Shepherd's Inn(Apartments)	12603-135 Avenue	Edmonton	T5L 5B3	1999	2
Shepherd's Manor Kensington Village	12603 - 135 Avenue	Edmonton	T5L 5B3	1997	2
Shepherd's Place	13441-127 Street	Edmonton	T5L 5B6	1997	1
Shepherd'sLodge Kensington Village	12603-135 Avenue	Edmonton	T5L 5B3	1997	2
Southside Manor	10741 - 29 Avenue	Edmonton	T6J 5H6	1993	2
St. Andrew's Centre	12720 - 111 Avenue	Edmonton	T5M 3X3	1980	2
St. Michael's Manor	106 Avenue and 104 Street	Edmonton		1999	2
St. Michael's Millennium Pavilion	7408 - 139 Avenue	Edmonton	T5C 3H7		2
Summerlea House	9420 - 172 Street	Edmonton			7
Sunset Lodge	11034 - 124 Street	Edmonton	T5M 0J3	1957	2
Tegler Manor	9943 110 Street	Edmonton	T5K 2N5	1983	2
Tegler Terrace	9918 - 149 Street	Edmonton	T5P 4X2	1993	2
The Churchill	10015-103 Avenue	Edmonton	T5J 0H1	1999	1
The Churchill	100015-103 Avenue	Edmonton	T5J 0H1	1999	1
The Manor Riverbend	200 Falconer Crescent	Edmonton		1999	1
The Meadows	13320-124 Street	Edmonton	T5L 5B7	1997	1
The Waterford of Summerlea	9395 - 172 Street	Edmonton	T5T 5S6	1989	1
Ukrainian Senior Citizens Home of the Holy Eucharist	11935 - 65 Street	Edmonton	T5W 4L5	1967	2
YWCA Building	103 Street and 100 Avenue	Edmonton			1
Fort Saskatchewan Supportive Housing	93 Avenue & 100 Street	Fort Sask.		1999	1
Edith Cavell Assisted Living	1255-5th Avenue South	Lethbridge	T1J 0V6		1
Chinook Village	1395-28 Street	Medicine Hat	T1A 8N7	1996	2
Meadowlands Retirement Residence	223 Park Meadows Drive SE	Medicine Hat		1999	1
Valleyview	SW	Medicine Hat		1999	1
Assisted Living Project at Pines Lodge	52 Piper Drive	Red Deer		1999	2
Victoria Park	9 Avery street SE	Red Deer	T4R 2S8	1998	1
Westpark Lodge	5715-41 Street Crescent	Red Deer	T4N 1B3	1996	1
Woodlea Cottage	5249-40 Avenue	Red Deer	T4N 6Y7	1994	1
Silver Birch Lodge	910 Bison Way	Sherwood Park	T8H 2C4	2000	2
The Country Cottage	75 Cranford Way	Sherwood Park		1999	1
The Park Housing Society Project	Near Our Lady of Perpetual Help Church	Sherwood Park		1999	2
Parkview	(no land yet)	Spruce Grove		1999	2
Ironwood Estates	40 Ironwood Point	St. Albert	T8N 6C7	1997	1
Mission Hill	78 McKenney Avenue	St. Albert	T8N 5R8	2000	2
Northtown Village	4710 - Northmount Drive	Wetaskiwin	T9A 3P6	1995	2

Appendix G

Policy Implications For Future Continuing Care Scenarios

Major Topic Area: I: SERVICES PROVISION

Chosen Scenario: #1, front end load, then #2
Chosen Scenario: 3
Scenario 2: "Medium Shift"

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
Eligibility criteria – will the eligibility criteria change in any way?	Everyone is eligible unless: 1) not competent due to cognitive impairment 2) a risk to themselves and/or others 3) care needs are beyond a certain level. • Modifiers 1) an individual (informal caregiver) able to assume responsibility for the person 2) person may wish to purchase care over a set level.	• eligibility should not be based on ability to pay • individuals requiring 24 hour supervision or care more easily supported than in home living • level of cognitive functioning can be supported in environment • variety of options – small group settings as well as larger • need to ensure ability to pay does not prevent access – ie. safety net	• require 24 hour professional care • high level of physical or mental needs professional care required • higher technological needs – ie. ventilators, dialysis • late stage dementia
	• allow for preventive home care services • home care standards needed • $3,000 / month (eligibility vs. affordability) – examine costs • based on ability to pay, you may have access to services and stay at home • look at different classification system – add availability of resources – use a matrix – a 2 pronged approach – all variables to be worked in including financial – to be done by professionals (case manager) • enhance supports required • investigate income testing • investigate asset testing • investigate ethical issues – moving from long term to other levels for example • should only be required to be a resident of alberta and have a phn • be client focused – address needs	• look at different classification system – add availability of resources – use a matrix – a 2 pronged approach – all variables to be worked in including financial – to be done by professionals (case manager) • enhance supports required • investigate income testing • investigate asset testing • investigate ethical issues – moving from long term to other levels for example • ability to self select re housing component – be able to go before you need the level of care – person may be able to provide some services / support to others – keeping couples together • home care standards needed • should only be required to be a resident of Alberta and have a PHN • be client focused – address needs	• look at different classification system – add availability of resources – use a matrix – a 2 pronged approach – all variables to be worked in including financial – to be done by professionals (case manager) • enhance supports required • investigate income testing • investigate asset testing • investigate ethical issues – moving from long term to other levels for example • should only be required to be a resident of Alberta and have a PHN • no preference policy – 1st available bed • cross border access • 24 hour care • be client focused – address needs
	• nurse assesses but often there are not enough nurses or other professionals to provide the services	• single assessment to delineate into which stream a person is placed • no criteria can be dictated for private	• a fluid way to allow people to move back into other streams • based on needs

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
	• balance between clients' desire and what resources are available • shared responsibility – client's family has some responsibility • social supports – social needs must be assessed as well • based on (un-met) needs • single point of entry – reassessment process as peoples' needs change • (will the classification system always be the same?) • decision to stay at home is one's own choice • public funding – everyone must be treated similarly across the streams - ex. Pharmaceuticals, therapies, etc.	enterprise providers who are not using public funds • if a facility if publicly-funded, then eligibility is based on needs	• a new assessment tool required which constantly determines current situation • standardize the assessment tool
Type of services offered – are there additional, alternative services that need to be available?	• professional services based on assessed need – geriatric assessments • multiskilled staff for personal care and delegated skills – personal care could be cost-shared • shelter at personal cost but homemaking needs to be available based on ability to pay • utilize technology to support individual • respite services, day programs, transportation • education for care givers	• services available 24 hours a day. • services provided split between health and housing. • ability to purchase additional services • menu of services available for individual to choose from	• professional health services based on assessed need • personal care could be cost shared • hotel/housing individual cost based on ability to pay • higher technical services provided in the environment
	• more day programs on an organized basis in community for people living at home to do outside of the home • services should cross more interdepartmental boundaries • needs to be more choice – individualized to client from basic personal care to RN • centralization of governance on a regional level • transportation needs must be addressed • more respite • consider that private equals profit – and that there is a role for government to own and manage but government must be more efficient – how can private offer better services (or the same services) at the same or lower cost and still make a profit? • case management – team approach • seamless access from home to supported	• more day programs on an organized basis in community for people living at home to do outside of the home • services should cross more interdepartmental boundaries • needs to be more choice – individualized to client from basic personal care to RN • centralization of governance on a regional level • transportation needs must be addressed • more respite • consider that private equals profit – and that there is a role for government to own and manage but government must be more efficient – how can private offer better services (or the same services) at	• needs to be more choice – individualized to client from basic personal care to RN • centralization of governance on a regional level • transportation needs must be addressed • more respite • case management – team approach • seamless access from home to supported living to facility and vice-versa • resources financial and human are necessary to implement plans • information services across / within regions (inter and intra) • care map (multi discipline) • services to be provided to a "critical

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
	living to facility and vice-versa • resources financial and human are necessary to implement plans • information services across / within regions • (inter and intra) • care map (multi discipline) • services to be provided to a "critical mass" – e.g. dialysis, brain injured, MS, ALS. • ability to provide palliative care across spectrum • more geriatric specialty services or training in that area • more services going where clients are (diagnostic, physician)	the same or lower cost and still make a profit? • case management – team approach • seamless access from home to supported living to facility and vice-versa • resources financial and human are necessary to implement plans • information services across / within regions • (inter and intra) • care map (multi discipline) • services to be provided to a "critical mass" – e.g. dialysis, brain injured, MS, ALS. • ability to provide palliative care across spectrum • more geriatric specialty services or training in that area • more services going where clients are (diagnostic, physician)	mass" – e.g. dialysis, brain injured, MS, ALS. • Ability to provide palliative care across spectrum • More geriatric specialty services or training in that area • More services going where clients are (diagnostic, physician)
	• need more: - home care - respite care - palliative care - day programs - night care - transportation • more social systems • more community supports • more monitoring by all, especially by the health system • meals on wheels • physicians need to do (more) home visits • team approach • travelling labs, x-ray services, etc. • enhanced self-managed care • home visits by pharmacists, home deliveries of pharmaceuticals • home visits by a myriad of professionals and others who enhance the quality of life • homes need to be made senior-compatible	• same as for the home living stream • the stream must be clearly defined • provision of services must be "spelled out" • basic standards set for publicly-funded facilities • facilities which are specialized based on specific needs ex. a home especially for alzheimer's patients (but with client choice) • information provision regarding what services are available	• more opportunities for the choice program • part-time placement • a wider menu of services • renovations to existing facilities to offer private rooms and/or specialized facilities, programs and/or environments • holistic and alternative therapies
Human resources – what type of staff will be required? What type of training will be	• consultative teams and multiskilled workers • <u>support</u> for caregivers	• case coordination (appropriately trained) • professional support to families	• care providers must be encouraged who possess skills and attitudes friendly to clients with high physical

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
necessary? Who takes the leadership in planning services?	• educational assistance • case coordination (appropriately trained) • physicians	• multi-skilled teams • social support – community services • housing staff with a knowledge/skill to support frail elders	and cognitive needs • interdisciplinary teams • geriatric specialists – eg. md. rn.
	• multi-skilling • standards – training • in rural areas some services could be handled by local (trained, reimbursed?) family – friends etc. – the case manager would be the only one to move – care givers would remain • training of client – preventive – awareness of behaviors • multi-sectoral support (legal etc.) • as technology increases, training is needed to ensure effective use	• multi-sectoral support (legal etc.) • as technology increases, training is needed to ensure effective use • training to address needs of the higher needs clients (e.g. dementia)	• appropriate training for staff to deal with increase in acuity (palliative e.g.) • look at professional mix (enrich it) • multi-sectoral support (legal etc.) • as technology increases, training is needed to ensure effective use
	• train family members • education and support for families • more access to an interdisciplinary team at all levels • cross-training for professionals to merge disciplines (one professional can do many things rather than sending a parade of professionals to the home) • more respite facilities • personal care workers need standardized educational programs • training programs for home care workers have to be made affordable and attractive • seniors must be involved, at all levels, in naming the services which are provided • more discharge planning • more multi-level care consultants	• as in the home-living stream • more discharge planning • team approach • provide security • case management • more multi-level care consultants	• as in home-living • more discharge planning • more specific (geriatric) training • more multi-level care consultants

Major Topic Area: II: FUNDING

Chosen Scenario: SCENARIO #3
Chosen Scenario: 2
Chosen Scenario: 2

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
Funding – who pays for professional care (nursing, rehab, social work, etc.)?	• public health care • unless individual wishes not to participate • or extra or different care not proven to be beneficial (not publicly funded)	• public health care • unless individual wishes not to participate	• public health care • unless individual wishes not to participate
	▪ as it is now – the provincial government/taxpayers ▪ also one idea to charge client if they are in a position to pay, in addition to Alberta Health and Wellness ▪ to what degree should a person get support? Equivalent of cost of institutional care/but in the short term if needed can get more	▪ provincial government/ taxpayers	▪ Provincial government/ taxpayers
	• Government will be expected to pay to a pre-determined standard level • core of system should be paid by government • coordinated seamless system that is paid by government • give incentives for those in need of care to remain in home until it is unfeasible to remain there (an assessment and economic indicators will determine feasibility)	• government will be expected to pay to a pre-determined standard level • core of system should be paid by government • coordinated seamless system that is paid by government	• government will be expected to pay to a pre-determined standard level • core of system should be paid by government • coordinated seamless system that is paid by government
Funding – who pays for • Personal care	• government funded • consider some user pay or co-payment (no consensus) • some incentive for care givers to be cost effective	• government funded • consider some user pay or co-payment(no consensus) • some incentive for care givers to be cost effective	• government funded • consider some user pay or co-payment(no consensus) • some incentive for care givers to be cost effective
• Support e.g. home making	• shared between government and individual (based on income) • base level fully funded (based on need, not want)	• shared between government and individual (based on income) • base level fully funded (based on need, not want)	• shared between government and individual (based on income) • base level fully funded (based on need, not want)

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
	• government funded • consider some user pay or co-payment (no consensus) • some incentive for care givers to be cost effective • shared between government and individual (based on income) • base level fully funded (based on need, not want)	• government funded • consider some user pay or co-payment(no consensus) • some incentive for care givers to be cost effective • shared between government and individual (based on income) • base level fully funded (based on need, not want)	• government funded • consider some user pay or co-payment(no consensus) • some incentive for care givers to be cost effective • shared between government and individual (based on income) • base level fully funded (based on need, not want)
	• 3 steps to determine funding: • Step 1- Government will be expected to pay to a pre-determined standard level appropriate to stream (need-based standard) • Step 2 – A "sharing concept" between government and client on services that are above the standard but client will have difficulty in paying for • Step 3 – Client is expected to pay • ("Sharing Concept" will require clarification of boundaries)	• 3 steps to determine funding: • Step 1- Government will be expected to pay to a pre-determined standard level appropriate to stream (need-based standard) • Step 2 – A "sharing concept" between government and client on services that are above the standard but client will have difficulty in paying for • Step 3 – Client is expected to pay • ("Sharing Concept" will require clarification of boundaries)	• 3 steps to determine funding: • Step 1- Gov't will be expected to pay to a pre-determined standard level appropriate to stream (need-based standard) • Step 2 – A "sharing concept" between government and client on services that are above the standard but client will have difficulty in paying for • Step 3 – Client is expected to pay • ("Sharing Concept" will require clarification of boundaries)
Funding – who pays for housing: • capital costs • housing • operating costs	• individual • incentives for adaptation • educate baby boomers on construction of 'retirement homes'. • required to be cost effective. • home owner • some income tested assistance.	• shared between government, individual (through rent – based on income with a cap) and some community organizations. • required to be cost effective. • may be different rules based on type of housing • rents must go up • individual and government	• Remember, increased standards equal increased costs. • Shared between government, individual (through rent – based on income with a cap) and some community organizations. • Required to be cost effective. • May be different rules based on type of housing • Rents must go up • Individual and government (note; as the sophistication of the facility goes up, the government's portion of operational costs goes up)
	▪ individual for both capital and operating but government programs that help on a one time basis (i.e. to improve access and make home improvements to allow person to stay in home longer – practical and appropriate with a maximum amount and income tested	▪ capital – lodges should be responsibility of provincial and municipal government for lower income people – also for Seniors Housing ▪ capital – for private developers – could be an incentive for developing	▪ capital – government or private developer – could involve some local fundraising ▪ operating – provincial taxpayer/gov't for those who can't pay - income tested resident charge needs to be higher

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
		housing for individuals who could pay for it and want this type of housing ▪ mentioned that too much government support may be disincentive for private sector ▪ take an income support approach – establish a basic standard and let people choose ▪ operating costs – individual responsibility (in monthly charge)	
	• primarily the client • gov't may assist in selected areas where appropriate (ie. ramps, upgrades for mobility, asb program to assist for basic needs and unexpected costs according to income, aid to daily living) • non-profits may provide funding assistance in communities	• primarily the client • government may assist in selected areas where appropriate (ie. ramps, upgrades for mobility, asb program to assist for basic needs and unexpected costs according to income, aid to daily living) • non-profits may provide funding assistance in communities	• client pays for room in facility • government pays for selected other areas where appropriate (fire standards, care support space, security) • grey areas between client and government responsibility need to be addressed in this stream
Funding services – are changes needed in the cost sharing/subsidy structure? Should income testing?? Be considered for some of the services? (amount, what they are assessed for and how they are assessed)?	• Yes • set a base rate at a reasonable level • examine asset testing for accommodation (no consensus)	• yes • set a base rate at a reasonable level • examine asset testing for accommodation (no consensus)	• yes • set a base rate at a reasonable level • examine asset testing for accommodation (no consensus)
	▪ yes, there needs to be change ▪ yes to income testing ▪ asset testing with some exemptions (i.e. home) ▪ where there are charges there needs to be income testing ▪ need NEW funding model – overhaul the whole system versus just making changes here and there ▪ maximum amount per month based on needs ▪ transportation assistance form home to care area ▪ idea – care allowances – assess and give to person or family caregiver to decide what care/services to spend money on(self-managed care)	▪ yes, there needs to be change ▪ yes to income testing ▪ incentive program for supportive services /qualified health professional (i.e. nurse, pharmacist, etc) to visits residents ▪ community can contribute ▪ transportation needs to be addressed	▪ yes, there needs to be change ▪ yes to income testing ▪ higher charges for people who have resources ▪ income tested/assets ▪ private facility – user pay outside the public system ▪ need another level of facility between supportive living and continuing care

Policy Area	Home Living Stream	Supportive Living Stream	Facility-Based Stream
	• to meet scenario 2, this area needs to be enhanced by greatly increased funding in the future • philosophical/ strategies need to be reviewed in this area including (income testing, asset testing	• philosophical/ strategies need to be reviewed in this area including (income testing, asset testing)	• philosophical/ strategies need to be reviewed in this area including (income testing, asset testing)

Major Topic Area: III: LEGISLATION, STANDARDS

Chosen Scenario: 3

Chosen Scenario: Three: Highest Shift

Policy Area	Home Living Stream	Supportive Living Stream	Facility Based Stream
Legislation – what changes will be needed to legislation?	• standardized legislation across the entire continuing care spectrum • community transportation particularly rural • government wide collaboration to accomplish the mandate of scenario 3 • incentives public and private care-givers	• allow clients to live at risk • accessible/affordable housing • physician remuneration focused toward wellness • change provincial accounting practices to enable collaboration across government departments	• gate and access needs to be broadened • seems to be in better shape than - supportive / home streams • terminology needs to be standard . everyone must use the same language • change provincial accounting practices to enable collaboration across government departments
	• changes to income tax & social development act • changes in home care regulations • may need a home care act/community care act • building code – provincial or municipal act	• incentives for income support • home care act • don't wan too much here – handle it in standards • establish regulations • keep it simple • flexible • update legislation	• outdated – need updated legislation • building codes • need continuing care services act • (comprehensive legislation to cover all streams)
Standards – are standards needed? If so, what type of standards?	• cross regional health authorities basic coverage with flexibility • update standards regularly • determine provincial core services • living/accommodation standards	• update standards regularly • minimum education standards for support workers • adequate staff with adequate benefits and client ratio • "spend it or loose it" philosophy needs to be addressed as no incentive exists within that philosophy	• choice to live within limits (not a risk to others) • update standards regularly • adequate staff • adequate benefits • adequate client ratio's • standards for quality of services and care' staffing and architectural design
	• building codes may be necessary (like Denmark) • home adaptation program • entry to practice (qualification of workers) • standard classification of	• accountability measures for private & non-profit providers (flexible & meaningful) • entry to practice • classification system • similar to the ones in home living	• entry to practice • classification system • see the current legislation • accreditation is one tool for compliance of standards

	residents • standards for informal care givers (define that) and what support they provide • what to watch for the monitors • could be private services • competition • standards for basic level of care • standards for delivery (home care workers, etc) • accreditation exists	• coordinated agreement in roles of partners • lodge operating standards do exist do exist for some	
Monitoring – who will be responsible for monitoring the system provincially? Locally?	• gov't to contract monitoring for performance and accountability • mandatory accreditation • gov't oversight of regulations • prov gov't/locally by the rha's	• contract monitoring for performance and accoutability • provincial responsibility—qualified' independant evaluators for sevices and environment "with clout" • prov gov't/locally the rha's	• prov gov't / locally RHA's
	- rha's to develop a system - monitor the services provided rather than the locations due to the difficulty of getting into people's homes - review committee (provincial driven to ensure standards) - each region should have mechanism to monitor - district care centres – more than the 17 rha's to monitor provincial standards (& provide equipment & training) - home care & public health workers can do monitoring	• similar to home living (rha delegated) • peer groups, other groups to work with rha's (3 tier system to monitor the care, operations and buildings) • consumer directory – meets certification/ standards • seniors' housing groups in partnership with government and others to do it	• see legislation • need RHA's to coordinate their efforts and involvement throughout • provincial monitoring standards needed • Health Facilities Review Committee – but Government should take stronger stand
Special Issues: In what areas are there roles for the private and voluntary sectors? What type of partnerships should be considered by the government?	• monitoring of 75> in terms of future needs/prevention • care-giver respite recognition • consistent multi-year funding • homemaking/home support should be available and provided based on need/finances	• more partnerships between advanced education/large post secondary institutions and rural regions • fund the person' not he place (age in place) • drugs - no longer covered ->cover again' not yet covered -> cover' consideration for longer drug coverage after hospital discharge • all types of partnerships should be considered (all streams)	• education quotas must be increased for all professional categories at all educational institutions • bridging between formal and informal systems (caregivers, family professionals etc.) • need for immediate help for those who require service related to mental health • continuing education funding should be provided for all health professionals (now only given to doctors)

	• supply of home care workers (new path in work force to increase skills in areas) • social issues: loneliness, safety, nutrition, isolation • people with special needs staying in their homes • need to teach family if we keep people in homes & provide incentives • equivalent of provincial monitoring standards in communities • inequity of service delivery across province • fixed costs of house & drugs impact ability to pay for transportation, food, social activities, etc • costs have to be paid by the person living at home; adjust income tax (incentives to save for retirement) • some people won't be able to save no matter what, so we have to address that (adequate income support) • home maintenance & cleaning is an issue for home living	• some facilities don't provide home care & medication distribution (equity of service) • types of care & qualifications of home care workers or other help (personal care workers) • liability is an issue • role clarification and cross-over of professions • people with dementia have trouble mixing with those who are mentally well (small settings seem to mix better) • building designs are not always appropriate for D & E	• people with dementia have trouble mixing with those who are mentally well (small settings seem to mix better) • building designs are not always appropriate for F & G (some current ones) • funding and staffing has not kept up with the demand and present facility levels • qualification of staff (and recruitment) • the perception of impersonal care in big facilities